

CERTIFICATE OF DEATH

12825

12825

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First CHARLIE	Middle EMORY	Last ARCHER	2a. DATE OF DEATH Month 9	Day 19	Year 68	2b. HOUR 12:35	
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH 5-26-05		6. AGE (In years last birthday) 63	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 0	
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Cecil				
10. CITY OR TOWN OF DEATH Perry Point	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Handyman				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia	13b. COUNTY Merrifield	13c. CITY OR TOWN Merrifield	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER Box 174				
14. FATHER'S NAME First Houston	Middle Archer (D)	Last	15. MOTHER'S MAIDEN NAME First Willie	Middle	Last Priest (D)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. WW II	16c. INFORMANT VA Hospital Records, Perry Point, Md.	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute and chronic pulmonary edema APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4129								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Congestive heart failure								
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic coronary heart disease								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION 4/20/1	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from Feb. 15 , 19 68 to Sept. 19 , 19 68 , exempt exempt exempt and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE A. L. Mooney, M.D.	DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 9-20-68				
22d. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.	22e. ADDRESS VA Hospital, Perry Point, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 19/23/68	23c. NAME OF CEMETERY OR CREMATORIAL Family Cemetery	23d. LOCATION (City or Town) Roxbury, Howard County, Md.	(County) Howard	(State) Md.			
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.	25d. ADDRESS Lee A. Patterson & Son, Perryville, Md.	25e. REC'D BY REGISTRAR Charles Judge		25f. REGISTRAR'S SIGNATURE Charles Judge				
DATE SEP 27 1968		DATE SEP 27 1968						

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12826

12836

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the attending physician. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First DAVID	Middle L.	Last ATWELL	2a. DATE OF DEATH Month 9	Day 14	Year 68	2b. HOUR 8:20a M
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1-25-15		6. AGE (in years last birthday) 53 YRS.		IF UNDER 1 YEAR MDNTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Cecil County		
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VA Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Government Emp. Federal		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Grace Hayre De		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 630 Linden Lane	
14. FATHER'S NAME First Simon		Middle Atwell	Last	15. MOTHER'S MAIDEN NAME First Margaret Bogle				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) WW II 215-18-83-59		17. INFORMANT VA Hospital Records - Perry Point, Maryland		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129		VENTRICULAR FIBULLATION				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease						
DUE TO, OR AS A CONSEQUENCE OF (b)								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200 Cerebral arteriosclerosis								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22. I certify that Ben Rothfeld (this hospital) attended the deceased from 5-31-68 , 19 68 , to 9-14-68 , 19 68 , that Ben Rothfeld did not see the deceased alive on 9-14-68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Ben Rothfeld M.D.		22c. DATE SIGNED 9 14 68						
22d. PHYSICIAN'S NAME (Type) BENJAMIN ROTHFELD, M.D.		22e. ADDRESS VA Hospital - Perry Point, Maryland						
23a. BURIAL/CREMATION, REMOVAL (Specify)		23b. DATE 9/17/68		23c. NAME OF CEMETERY OR CREMATORIAL Angel Cemetery		23d. LOCATION (City or Town) Havre de Grace, Md.		
24. FUNERAL DIRECTOR PENNINGTON & SON		ADDRESS Havre de Grace, Maryland		25a. REC'D BY REGISTRAR SEP 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Roy	Middle J.	Last Brock	2a. DATE OF DEATH Sept. 26 1968	2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH Jan. 7, 1899		6. AGE (in years last birthday) 69 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Tennessee	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH CECIL		
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) roofer		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 329 Hollingsworth Manor	
14. FATHER'S NAME James M. Brock	15. MOTHER'S MAIDEN NAME Idabelle Richardson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Mrs. Cynthia J. Brock, Elkton, Md.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 28		
4109 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last.					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary atherosclerosis</i>					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from <u>8/28</u> , 19 <u>68</u> , to <u>9/26</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9/26</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Edgar E. Brock III, M.D.</i>		22c. DEGREE DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) <i>Edgar E. Brock III</i>		22e. ADDRESS 115 Ave. "A" Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/29/68	23c. NAME OF CEMETERY OR CREMATORIAL Gilpin Manor Memorial Park, Elkton, Cecil, Md.	23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <i>Joseph E. Hicks</i>	ADDRESS Hicks Home for Funerals, Elkton, Md.	25a. RECD BY REGISTRAR DATE SEP 30 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12838

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Charles	Middle M.	Last Dennis, SR.	2a. DATE OF DEATH Month September Day 11, 1968 Year 2:30 PM	2b. HOUR IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
3. SEX Male	4. RACE White	5. DATE OF BIRTH July 6, 1902		6. AGE (In years lost birthday) 66 yrs.	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil	
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mechanic	12b. KIND OF BUSINESS OR INDUSTRY Auto
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER E. Frenchtown Rd.	
14. FATHER'S NAME John	Middle H.	Last Dennis	15. MOTHER'S MAIDEN NAME Laura	Middle J.	Last Heath
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Mrs. Mary B. Dennis, Elkton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <u>4129</u> (b) <u>Arteriosclerosis, Generalized, Severe</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>9-8-1968</u> to <u>9-11-1968</u> , that (I) (we) last saw the deceased alive on <u>9-11-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Charles D. Johnson</u>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>9-14-68</u>
22d. PHYSICIAN'S NAME (Type) <u>Tillman D. Johnson</u>		22e. ADDRESS <u>1235 1/2 Ave. Elkton, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/14/68	23c. NAME OF CEMETERY OR CREMATORIAL North East Meth. Cemetery, North East, Md.	23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Ralph E. Hicks</u> Hicks Home for Funerals, Elkton, Md.		ADDRESS	25a. REC'D BY REGISTRAR DATE <u>SEP 16 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE
HEALTH DEPT.

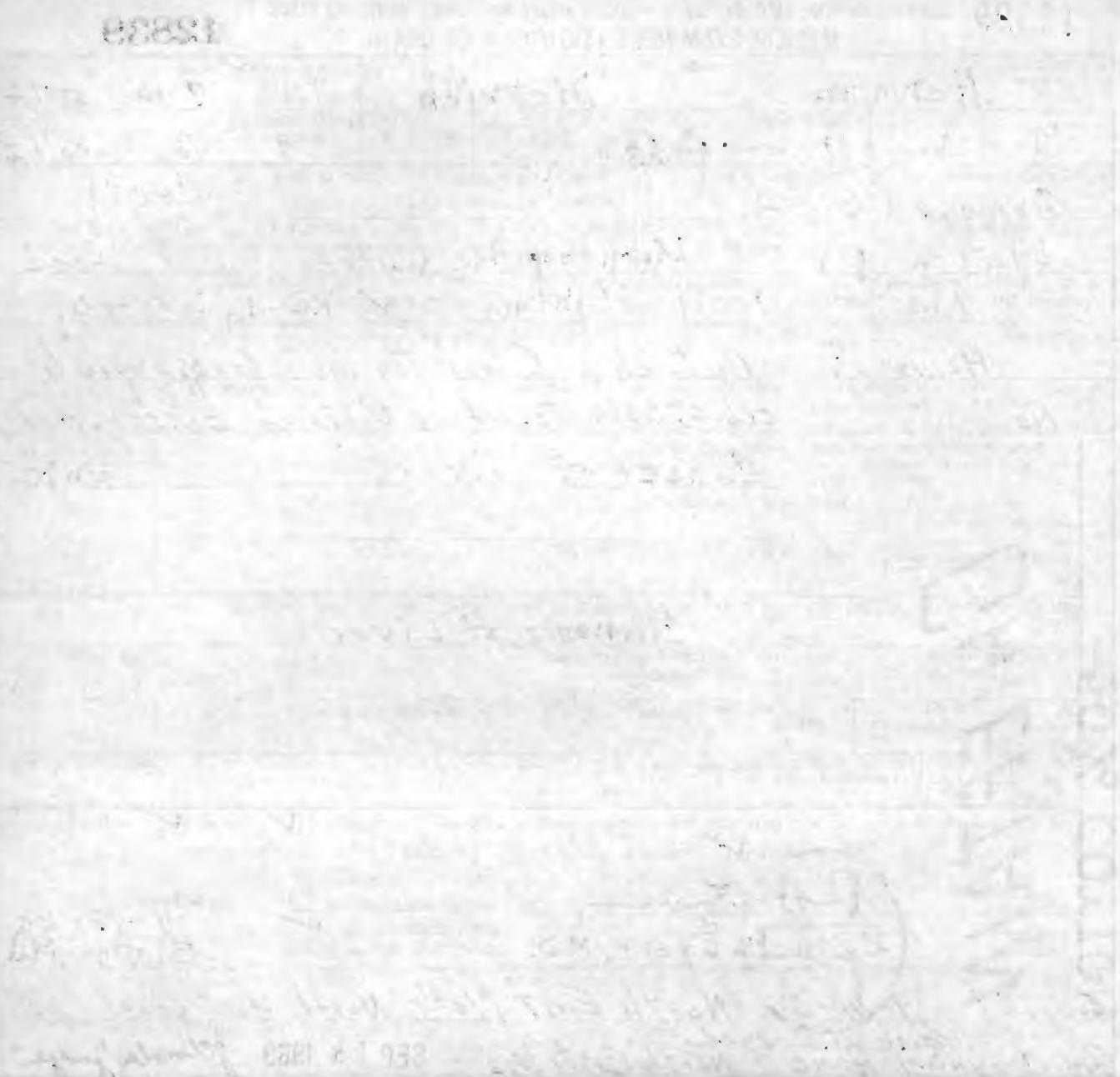
any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12829 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12839

1. DECEASED-NAME (Type or Print)	First <i>Herman</i>	Middle 	Last <i>Dietrich</i>	2a. DATE KNOWN OF DEATH MATED	Month 9	Day 16	Year 1968	2b. HOUR 165 7:45 A.M.					
3. SEX <i>M</i>	4. RACE <i>W</i>	S. DATE OF BIRTH <i>11-6-04</i>	6. AGE (In years last birthday) <i>63</i> YRS.	IF UNDER 1 YEAR MONTHS 	IF UNDER 24 HRS DAYS 	HOURS 	MIN. 	2c. DATE PRONOUNCED DEAD Month 9	Day 16	Year 1968	2d. HOUR 7:50 7:45 A.M.		
7a. BIRTHPLACE (State or foreign country) <i>Germany</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Cecil</i>										
10. CITY OR TOWN OF DEATH <i>Eikton</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Union Hosp. No. 1, Eikton</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Waiter</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Food</i>										
13a. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Cecil</i>	13c. CITY OR TOWN <i>Eikton</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>R.D. 1, Box 401</i>									
14. FATHER'S NAME First <i>Heinrich</i>	Middle 	Last <i>Dietrich</i>	15. MOTHER'S MAIDEN NAME First <i>Christina</i>	Middle 	Last <i>Grosswicke</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>086-03-5260</i>	17. INFORMANT <i>Josephine Dietrich</i>	ADDRESS <i>R.D. 1, Box 401, Eikton, Md.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>unk.</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>197.8</i> DUE TO, OR AS A CONSEQUENCE OF <i>Cancer of Liver</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Cirrhosis of Liver</i>													
MEDICAL CERTIFICATION <i>1561</i>	19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
	21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>WHILE AT WORK</i>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John M. Myers</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <i>Eikton, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9-14-68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>North East Meth.</i>		23d. LOCATION (City or Town) <i>North East Cecil, Md.</i>		(County), <i>Cecil</i>		(State) <i>Md.</i>			
24. FUNERAL DIRECTOR <i>Ralph J. Crouch</i>		ADDRESS <i>Grant Funeral Home</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 18 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



FOR STATE
HEALTH DEPT.



Any delay in filing pages 1, 2, and 3 to the Chief Medical Examiner's Office may result in the certificate being held pending in the Vital Statistics Division until the death is reported to the Office of Vital Statistics.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

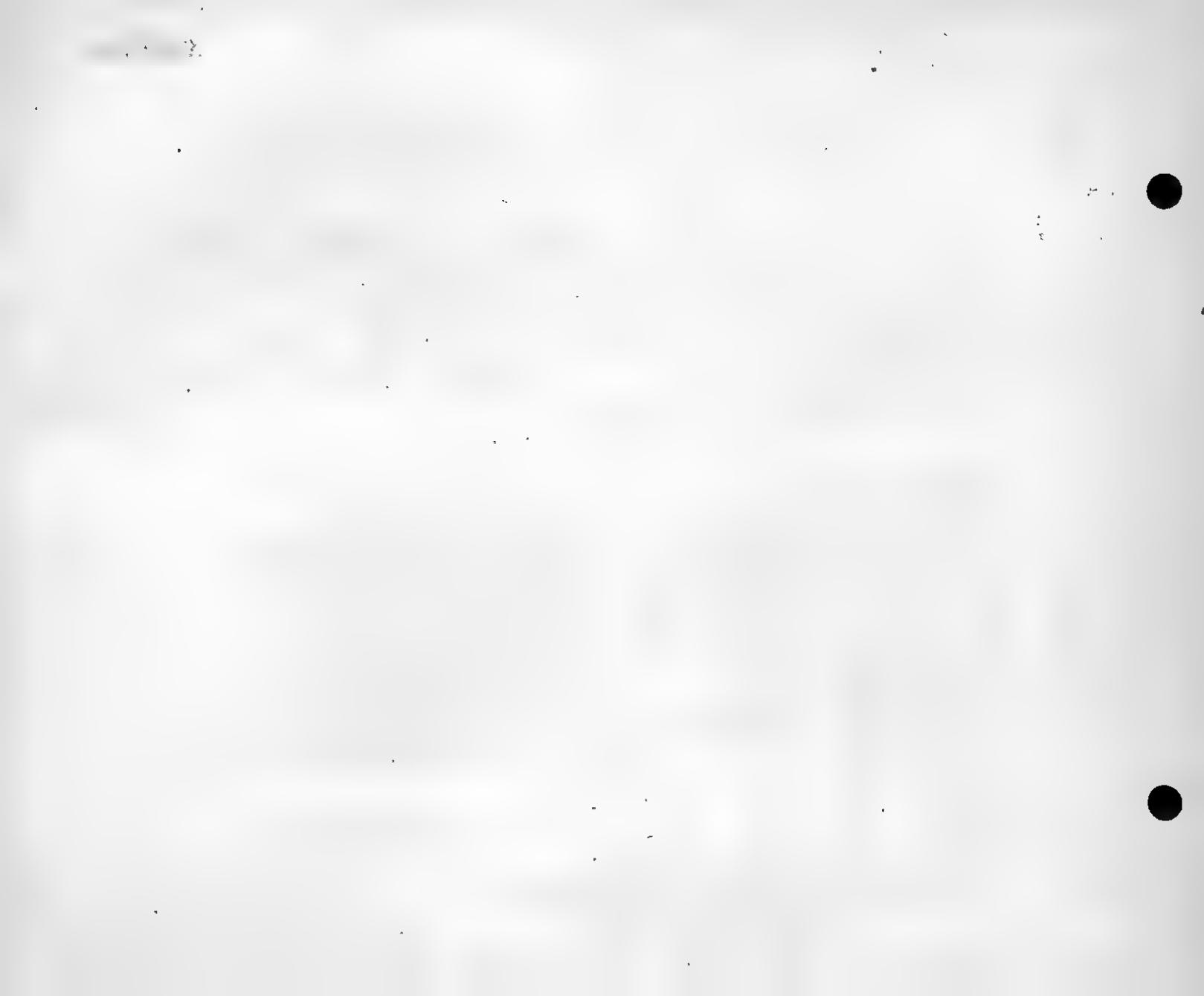
12830

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12840

1. DECEASED NAME (Type or Print)		First WALTON	Middle KIRK	Lost DINSMORE	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 9/10	Day 1968	Year A. M.	2b. HOUR 9:00				
3. SEX male	4. RACE white	5. DATE OF BIRTH		6. AGE (in years last birthday) 61 YRS	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	IF UNDER 24 HRS HOURS 0	IF UNDER 24 HRS MIN 0	2c. DATE PRONOUNCED DEAD Month September	Day 10	Year 1968	2d. HOUR A. M.	
7a. BIRTHPLACE (State or foreign country) MO.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Cecil							
10. CITY OR TOWN OF DEATH Rising Sun		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) STEAM FITTER		12b. KIND OF BUSINESS OR INDUSTRY GENERAL							
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Rising Sun		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER W. Main St.					
14. FATHER'S NAME HARRY		First DINSMORE	Middle 	Lost 	15. MOTHER'S M AIDEN NAME MARY		First JANE	Middle 	Lost 				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ARTHUR DINSMORE, RISING SUN, MD.		ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty Alteration of Liver DUE TO, OR AS A CONSEQUENCE OF 5/1/4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		19c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21d. LOCATION Street or R.F.D. No City or Town County State							
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												22b. DATE SIGNED 9/10/68	
ACTUAL SIGNATURE <i>Werner U. Spitz, M.D.</i>		EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county) RISING SUN, CECIL, MD.					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 9/13/1968		23c. NAME OF CEMETERY OR CREMATORIAL BROCKVIEW		23d. LOCATION (City or Town) RISING SUN, CECIL, MD.		(County)		(State)			
24. FUNERAL DIRECTOR RALPH M. REED		ADDRESS RALPH M. REED, RISING SUN, MD.		25a. REC'D BY REGISTRAR SEP 13 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

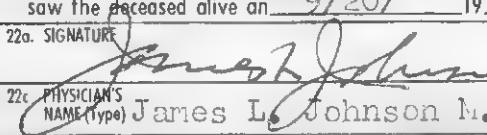
12831

CERTIFICATE OF DEATH

12841

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

11 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 5- Years		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital Of Cecil County			e. STREET ADDRESS Elk Neck		
3. NAME OF DECEASED (Type or print) Mary Ann Eller			4. DATE OF DEATH Month Day Year 9 20 1968		
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 9-9-1883	9. AGE (In years last birthday) 85 yrs
10a. US. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			11. BIRTHPLACE (County & State, or foreign country) North Carolina		
13. FATHER'S NAME Willis Houser			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Raymond Campbell (Daughter) Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema			INTERVAL BETWEEN ONSET AND DEATH 3- Days		
583X Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last.			DUE TO (b) Cardiac Failure 1- Month		
			DUE TO (c) Hypertension and Nephritis 2- Years		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 446X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (Physician) attended the deceased from 8/24/1968 to 9/20/1968 , that (I) (We) last saw the deceased alive on 9/20/1968 , and that death occurred at 8A: M , from causes and on the date stated above.					
22a. SIGNATURE 			22b. DATE SIGNED 9/20/68		
22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.		22d. ADDRESS 245 East High St., Elkton Cecil Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/23/68	23c. NAME OF CEMETERY OR CREMATORIAL Eller Cemetery		23d. LOCATION (City or Town) (County) (State) Jefferson Ash N.C.
24. FUNERAL DIRECTOR Ralph E. Hicks Hicks Funeral Home Elkton, Md.		ADDRESS	25a. RECD BY REGISTRAR SEP 26 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	

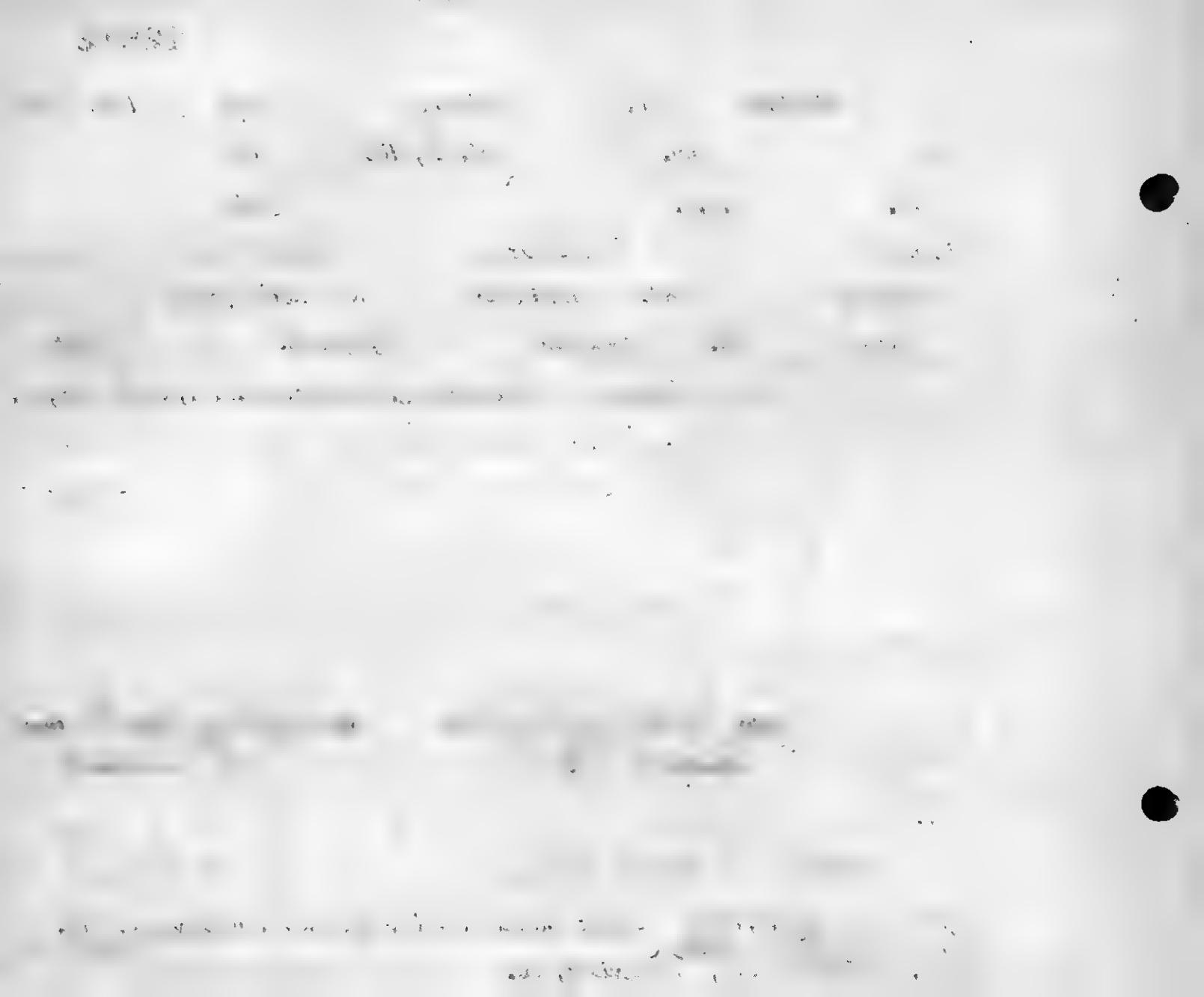


CERTIFICATE OF DEATH

12832

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First <i>William</i>	Middle <i>T.</i>	Last <i>Eshleman</i>	2a. DATE OF DEATH Month <i>Sept</i>	Day <i>3</i>	Year <i>1968</i>	2b. HOUR <i>4:30 P.M.</i>
3 SEX <i>Male</i>	4. RACE <i>Cau.</i>	5. DATE OF BIRTH <i>Oct. 27, 1885</i>		6. AGE (in years last birthday) <i>82</i>		IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Pa.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Cecil</i>			
10. CITY OR TOWN OF DEATH <i>Rising Sun</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Rock Springs</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Self Emp.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Cecil</i>	13c. CITY OR TOWN <i>Rising Sun</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>Rock Springs</i>			
14. FATHER'S NAME First <i>Henry</i>	Middle <i>H.</i>	Last <i>Eshleman</i>	15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i>	Middle <i></i>	Last <i>Fritz</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>Yes</i>	16b. SOCIAL SECURITY NO (If yes give war or dates of service) <i>Unknown</i>	17. INFORMANT <i>Elizabeth C. Eshleman, R.F.D., Rising Sun, Md.</i>	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>4109</i> DOUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>10-27</i> DOUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4109</i>							
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>At home, farm, street, factory.</i>	21d. LOCATION Street or R.F.D. No. City or Town County State <i>Rising Sun Cecil Md</i>			
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>							
22a. I certify that (1) (this hospital) attended the deceased from _____, 19_____, to 3 Sept, 1968, that (1) (we) last saw the deceased alive on _____, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did-not) view the body after death.							
22b. SIGNATURE <i>R. G. Doyle, M.D.</i>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>RUSSELL G. DOYLE, M.D.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Sept. 6, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Little Britain Presb. Cem. R.F.D. Quarryville, Pa.</i>	23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <i>Lee A. Patterson & Son, Perryville, Md.</i>		ADDRESS	25a. RECEIVED BY REGISTRAR DATE <i>SEP 11 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



CERTIFICATE OF DEATH

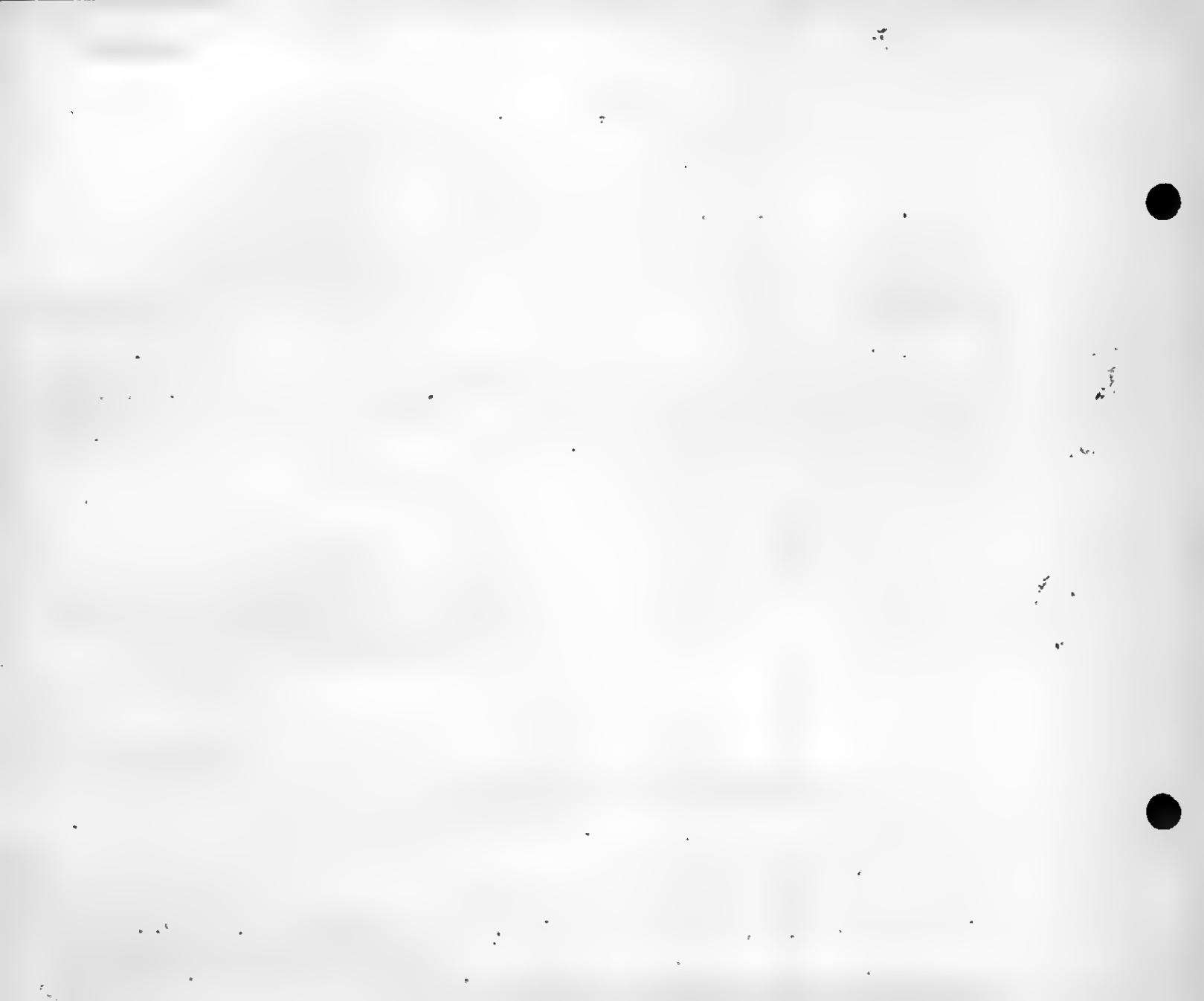
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	2b. HOUR 8:30-11 AM
Elizabeth		Marie	Funk	5	Year 1968
3. SEX	4. RACE	5. DATE OF BIRTH		6 AGE (In years lost birthday)	7. UNDER 1 YEAR MONTHS DAYS HOURS M.N.
Female	White	4/17/1905		63 YRS.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH		
Penna.	U.S.A.			Cecil	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret.ret.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital			Housewife	—
13a. USUAL RES.DENCE (Where deceased lived, if institution Res.dence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER	
Maryland	Cecil	Elkton	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Elk-side	R.D.2
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	Address
Stephen			Toner	Matilda	Frame
16c. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17 INFORMANT			
NO		David A. Funk, Elkton, Md. R.D.2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> lost.					
(b) <u>Arteriosclerotic 16.0</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
4201 <u>Gall bladder disease</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>7-20-1968</u> to <u>9-28-1968</u> , that (I) (we) lost saw the deceased alive on <u>9-28-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>9-28-68</u>
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS <u>Tillman Delahusen 7-12 123 Singletary Ave, Elkton, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE Oct. 1, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Glenwood Mem. Gardens	23d. LOCATION (City or Town) Broomall	(County) Penns.	(State)
24. FUNERAL DIRECTOR <u>Hicks Home for Funerals, Elkton, Md.</u>	ADDRESS	25a. REC'D BY REGISTRAR DATE SEP 30 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

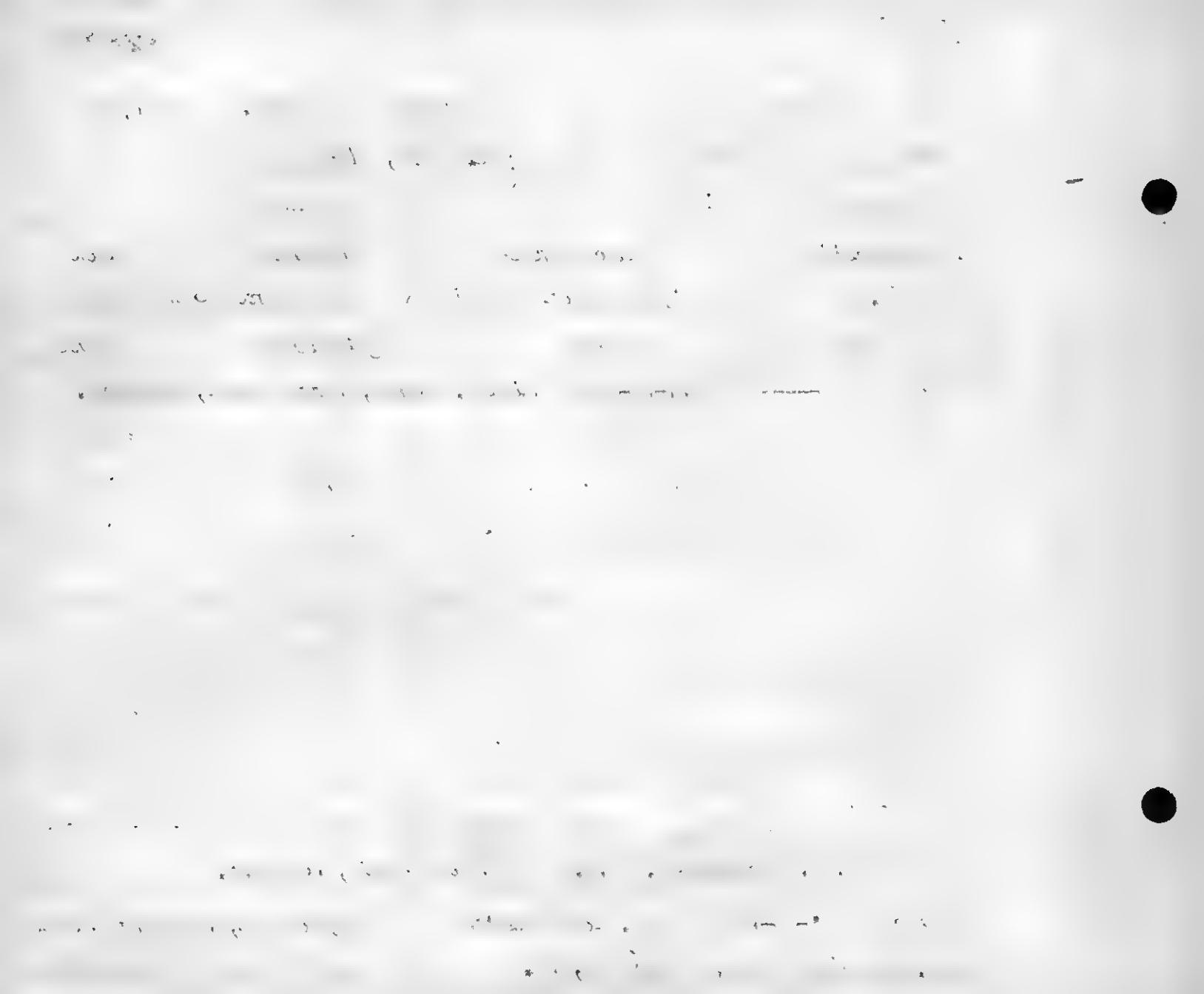
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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Conrad</i>	Middle	Lost	2a. DATE OF DEATH Month <i>Sept.</i>	2b. HOUR Day <i>24 1968 120 M</i>	
3. SEX <i>Male</i>	4. RACE <i>Negro</i>	5. DATE OF BIRTH <i>Dec. 26, 1885</i>		6. AGE (In years last birthday) <i>82</i>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Cecil</i>			
10. CITY OR TOWN OF DEATH <i>Port Deposit</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Center Street</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Labor</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Cecil</i>	13c. CITY OR TOWN <i>Port Deposit</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>Center Street</i>		
14. FATHER'S NAME <i>John</i>	First	Middle <i>Haines</i>	15. MOTHER'S MAIDEN NAME <i>Catherine</i>	Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> UNKNOWN <i>No</i>	16b. SOCIAL SECURITY NO. <i>214-14-8603</i>		17. INFORMANT <i>Nina B. Haines, Port Deposit, Maryland</i>	Address <i>Berry</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Throbs</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i>						
47- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>arterio sclerotic P.V.C.</i> 10 yrs						
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Brochial Asthma</i> 20 yrs						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>2717</i>						
19a. DATE OF OPERATION <i>2/28/68</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR DRIVING <input type="checkbox"/> CAUSE OF DEATH* (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>July 1966</i> , to <i>2-24-1968</i> , that (I) (we) last saw the deceased alive on <i>9-24-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>G. H. Richards Jr. M.D.</i>		DEGREE <i>M.D.</i>	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>9/28/68</i>
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>Port Deposit, Maryland</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>9-28-1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Zion Cemetery</i>		23d. LOCATION (City or Town) <i>Conowingo, Maryland</i>	(County) <i>Cecil</i>	(State)
24. FUNERAL DIRECTOR <i>Lee A. Patterson & Son, Perryville, Md.</i>	ADDRESS		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE		
30M REV <i>P&P</i>		DATE <i>OCT 1 1968</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12835

12845

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

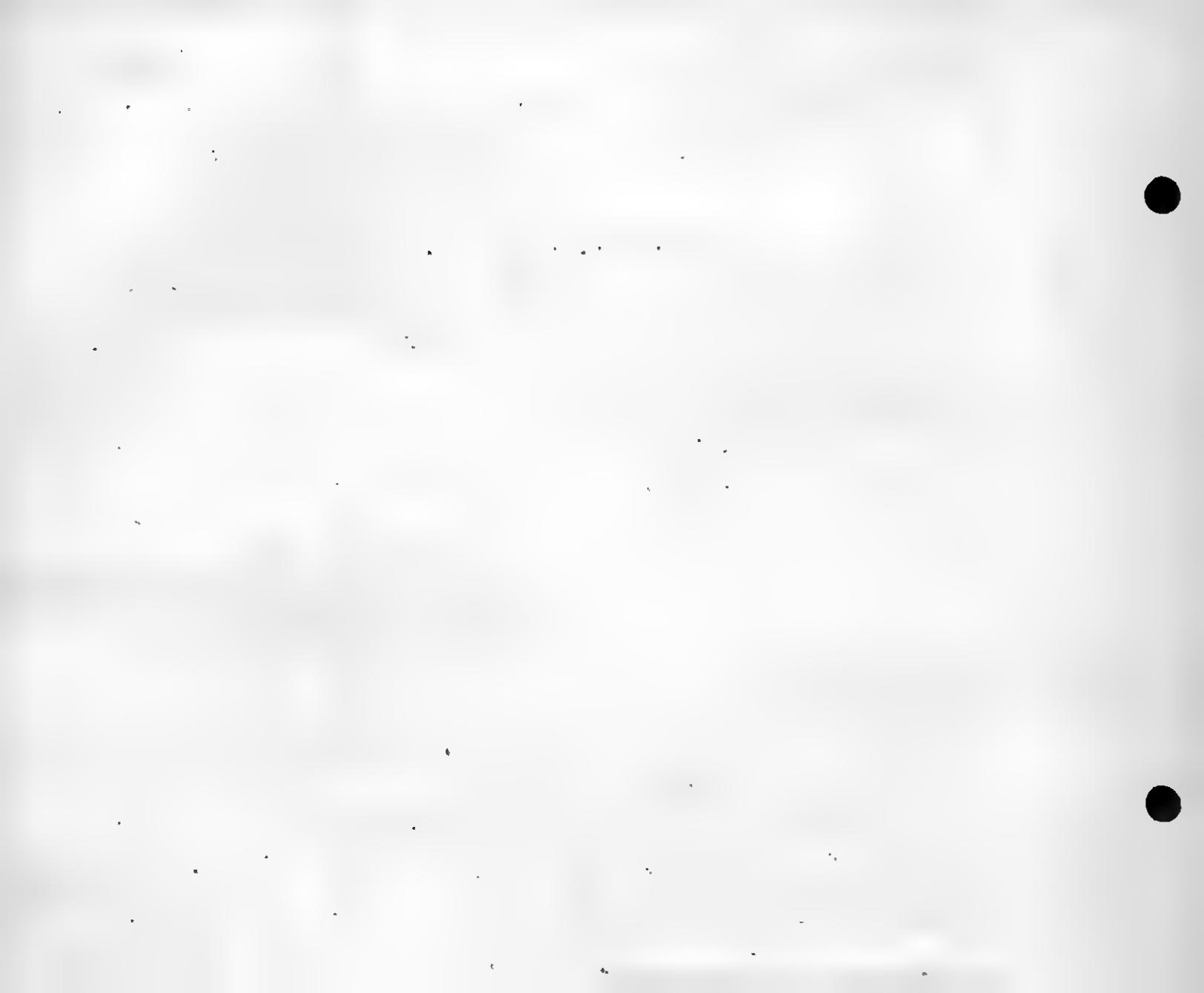
1. DECEASED NAME (Type or print)	First William	Middle A.	Lost Ham	2a. DATE OF DEATH Month September	Day 5, 1968	Year M	2b. HOUR
3. SEX Male	4. RACE White	5. DATE OF BIRTH March 10, 1890		6 AGE (in years lost birthday) 78	7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) North Carolina	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Cecil		Md.		
10 CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital g ve street address) Union Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Aerial Products		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admiss on) STATE Maryland	13b COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIM TS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER R.D.5 Cherry Hill			
14. FATHER'S NAME E.	Middle Ham	15. MOTHER'S MAIDEN NAME Elizabeth	16. SOCIAL SECURITY NO.		17 INFORMANT Mrs. Maggie C. Ham	Address Elkton, Md.	18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO.		17 INFORMANT Mrs. Maggie C. Ham		Address Elkton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF 4109 Cerebrovascular infarction Cerebrovascular disease 5 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from Sept. 19, 1963, to Sept. 19, 1968, that (I) (we) last saw the deceased alive on Sept. 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph G. Lanzi, M.D.		22c. DATE SIGNED 9/11/68	DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type) Joseph G. Lanzi, M.D.		22e. ADDRESS Elkton Medical Park					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/8/68	23c. NAME OF CEMETERY OR CREMATORIAL Cherry Hill Meth. Cen. Cherry Hill, Md.	23d. LOCATION (City or Town) Cherry Hill, Md.	(County) Md.	(State)		
24. FUNERAL DIRECTOR Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles George	DATE SEP 16 1968			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
12836 Film#G404 9/23/68 vmp CERTIFICATE OF DEATH 12846													
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR				
Victor				Jarva		Month	9	Day	9	Year	68 5:50PM		
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White			1/21/1885			88 83 YRS.					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
Finland		U.S.A.						Cecil					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Elkton		Union Hosp. of Cecil Co.											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER					
Delaware		Newark			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			92 Dixieline Road					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last			
Konsta Jarva					Lisa					Dulli			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CPR 77.4</i>													
4120 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause <i>(b) CHRONIC CARDIOVASCULAR KIDNEY DISEASE</i> <i>SOCK 24</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>PNEUMONIA</i> <i>YEARS</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. MEDICAL CERTIFICATE ON		19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year P.M. <input type="checkbox"/> 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>8/28/1968</i> to <i>8-17-1968</i> , that (I) (we) last saw the deceased alive on <i>SEPT 9 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Henry C. Davis</i>		22c. DEGREE ATTENDING PHYS.			<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.			22d. DATE SIGNED <i>9/9/68</i>					
22d. PHYSICIAN'S NAME (Type) <i>Henry C. Davis</i>		22e. ADDRESS <i>111 SAVANNAH 2nd Flr</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9-14-68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Pencader Cemetery</i>			23d. LOCATION (City or Town) <i>Glasgow, Delaware</i>		(County)		(State)		
24. FUNERAL DIRECTOR <i>Freeman & Ramick</i>		ADDRESS <i>Newark, Del.</i>			25a. REC'D BY REGISTRAR <i>Charles Judge</i>			25b. REGISTRAR'S SIGNATURE					
											DATE <i>SEP 18 1968</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 212847

CERTIFICATE OF DEATH

12837

12847

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)	First Edward	Middle V.	Last Jones	2a. DATE OF DEATH Month September Year 1968 2 P.M.	2b. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
3. SEX Male	4. RACE White	S. DATE OF BIRTH Aug. 3, 1908	6. AGE (in years lost birthday) 60 yrs.		
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Cecil		
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 59 Hollingsworth Manor	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Painter	12b. KIND OF BUSINESS OR INDUSTRY Painting		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 59 Hollingsworth Manor	
14. FATHER'S NAME First Edward	Middle Jones	15. MOTHER'S MAIDEN NAME First Emma	Middle Foreaker		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO W.72	17. INFORMANT 59 Hollingsworth Manor 219-03-0542	Mrs. Elanda E. Jones, Elkton, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary thrombosis</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs.		
410.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Coronary artery heart disease</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) <i>Several yrs.</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 14.12					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from <i>March 30, 1968</i> , to <i>Sept. 11, 1968</i> , that (I) (we) last saw the deceased alive on <i>Sept. 9, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>S. Ralph Andrews, Jr., M.D.</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 9-11-68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>233 E. Main St., Elkton, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/16/68	23c. NAME OF CEMETERY OR CEMFRATORY Baltimore National	23d. LOCATION (City or Town) Baltimore, Md.	(County) (State)
24. FUNERAL DIRECTOR <i>Ralph E. Hicks</i>		ADDRESS Hicks Home for Funerals, Elkton, Md.	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>Charles J. George</i>	DATE SEP 16 1968



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12838

12848

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pogos ¹ ² ³ ⁴ ⁵ ⁶ ⁷ ⁸ ⁹ ¹⁰ ¹¹ ¹² ¹³ ¹⁴ ¹⁵ ¹⁶ ¹⁷ ¹⁸ ¹⁹ ²⁰ ²¹ ²² ²³ ²⁴ ²⁵ ²⁶ ²⁷ ²⁸ ²⁹ ³⁰ ³¹ ³² ³³ ³⁴ ³⁵ ³⁶ ³⁷ ³⁸ ³⁹ ⁴⁰ ⁴¹ ⁴² ⁴³ ⁴⁴ ⁴⁵ ⁴⁶ ⁴⁷ ⁴⁸ ⁴⁹ ⁵⁰ ⁵¹ ⁵² ⁵³ ⁵⁴ ⁵⁵ ⁵⁶ ⁵⁷ ⁵⁸ ⁵⁹ ⁶⁰ ⁶¹ ⁶² ⁶³ ⁶⁴ ⁶⁵ ⁶⁶ ⁶⁷ ⁶⁸ ⁶⁹ ⁷⁰ ⁷¹ ⁷² ⁷³ ⁷⁴ ⁷⁵ ⁷⁶ ⁷⁷ ⁷⁸ ⁷⁹ ⁸⁰ ⁸¹ ⁸² ⁸³ ⁸⁴ ⁸⁵ ⁸⁶ ⁸⁷ ⁸⁸ ⁸⁹ ⁹⁰ ⁹¹ ⁹² ⁹³ ⁹⁴ ⁹⁵ ⁹⁶ ⁹⁷ ⁹⁸ ⁹⁹ ¹⁰⁰ ¹⁰¹ ¹⁰² ¹⁰³ ¹⁰⁴ ¹⁰⁵ ¹⁰⁶ ¹⁰⁷ ¹⁰⁸ ¹⁰⁹ ¹¹⁰ ¹¹¹ ¹¹² ¹¹³ ¹¹⁴ ¹¹⁵ ¹¹⁶ ¹¹⁷ ¹¹⁸ ¹¹⁹ ¹²⁰ ¹²¹ ¹²² ¹²³ ¹²⁴ ¹²⁵ ¹²⁶ ¹²⁷ ¹²⁸ ¹²⁹ ¹³⁰ ¹³¹ ¹³² ¹³³ ¹³⁴ ¹³⁵ ¹³⁶ ¹³⁷ ¹³⁸ ¹³⁹ ¹⁴⁰ ¹⁴¹ ¹⁴² ¹⁴³ ¹⁴⁴ ¹⁴⁵ ¹⁴⁶ ¹⁴⁷ ¹⁴⁸ ¹⁴⁹ ¹⁵⁰ ¹⁵¹ ¹⁵² ¹⁵³ ¹⁵⁴ ¹⁵⁵ ¹⁵⁶ ¹⁵⁷ ¹⁵⁸ ¹⁵⁹ ¹⁶⁰ ¹⁶¹ ¹⁶² ¹⁶³ ¹⁶⁴ ¹⁶⁵ ¹⁶⁶ ¹⁶⁷ ¹⁶⁸ ¹⁶⁹ ¹⁷⁰ ¹⁷¹ ¹⁷² ¹⁷³ ¹⁷⁴ ¹⁷⁵ ¹⁷⁶ ¹⁷⁷ ¹⁷⁸ ¹⁷⁹ ¹⁸⁰ ¹⁸¹ ¹⁸² ¹⁸³ ¹⁸⁴ ¹⁸⁵ ¹⁸⁶ ¹⁸⁷ ¹⁸⁸ ¹⁸⁹ ¹⁹⁰ ¹⁹¹ ¹⁹² ¹⁹³ ¹⁹⁴ ¹⁹⁵ ¹⁹⁶ ¹⁹⁷ ¹⁹⁸ ¹⁹⁹ ²⁰⁰ ²⁰¹ ²⁰² ²⁰³ ²⁰⁴ ²⁰⁵ ²⁰⁶ ²⁰⁷ ²⁰⁸ ²⁰⁹ ²¹⁰ ²¹¹ ²¹² ²¹³ ²¹⁴ ²¹⁵ ²¹⁶ ²¹⁷ ²¹⁸ ²¹⁹ ²²⁰ ²²¹ ²²² ²²³ ²²⁴ ²²⁵ ²²⁶ ²²⁷ ²²⁸ ²²⁹ ²³⁰ ²³¹ ²³² ²³³ ²³⁴ ²³⁵ ²³⁶ ²³⁷ ²³⁸ ²³⁹ ²⁴⁰ ²⁴¹ ²⁴² ²⁴³ ²⁴⁴ ²⁴⁵ ²⁴⁶ ²⁴⁷ ²⁴⁸ ²⁴⁹ ²⁵⁰ ²⁵¹ ²⁵² ²⁵³ ²⁵⁴ ²⁵⁵ ²⁵⁶ ²⁵⁷ ²⁵⁸ ²⁵⁹ ²⁶⁰ ²⁶¹ ²⁶² ²⁶³ ²⁶⁴ ²⁶⁵ ²⁶⁶ ²⁶⁷ ²⁶⁸ ²⁶⁹ ²⁷⁰ ²⁷¹ ²⁷² ²⁷³ ²⁷⁴ ²⁷⁵ ²⁷⁶ ²⁷⁷ ²⁷⁸ ²⁷⁹ ²⁸⁰ ²⁸¹ ²⁸² ²⁸³ ²⁸⁴ ²⁸⁵ ²⁸⁶ ²⁸⁷ ²⁸⁸ ²⁸⁹ ²⁹⁰ ²⁹¹ ²⁹² ²⁹³ ²⁹⁴ ²⁹⁵ ²⁹⁶ ²⁹⁷ ²⁹⁸ ²⁹⁹ ³⁰⁰ ³⁰¹ ³⁰² ³⁰³ ³⁰⁴ ³⁰⁵ ³⁰⁶ ³⁰⁷ ³⁰⁸ ³⁰⁹ ³¹⁰ ³¹¹ ³¹² ³¹³ ³¹⁴ ³¹⁵ ³¹⁶ ³¹⁷ ³¹⁸ ³¹⁹ ³²⁰ ³²¹ ³²² ³²³ ³²⁴ ³²⁵ ³²⁶ ³²⁷ ³²⁸ ³²⁹ ³³⁰ ³³¹ ³³² ³³³ ³³⁴ ³³⁵ ³³⁶ ³³⁷ ³³⁸ ³³⁹ ³⁴⁰ ³⁴¹ ³⁴² ³⁴³ ³⁴⁴ ³⁴⁵ ³⁴⁶ ³⁴⁷ ³⁴⁸ ³⁴⁹ ³⁵⁰ ³⁵¹ ³⁵² ³⁵³ ³⁵⁴ ³⁵⁵ ³⁵⁶ ³⁵⁷ ³⁵⁸ ³⁵⁹ ³⁶⁰ ³⁶¹ ³⁶² ³⁶³ ³⁶⁴ ³⁶⁵ ³⁶⁶ ³⁶⁷ ³⁶⁸ ³⁶⁹ ³⁷⁰ ³⁷¹ ³⁷² ³⁷³ ³⁷⁴ ³⁷⁵ ³⁷⁶ ³⁷⁷ ³⁷⁸ ³⁷⁹ ³⁸⁰ ³⁸¹ ³⁸² ³⁸³ ³⁸⁴ ³⁸⁵ ³⁸⁶ ³⁸⁷ ³⁸⁸ ³⁸⁹ ³⁹⁰ ³⁹¹ ³⁹² ³⁹³ ³⁹⁴ ³⁹⁵ ³⁹⁶ ³⁹⁷ ³⁹⁸ ³⁹⁹ ⁴⁰⁰ ⁴⁰¹ ⁴⁰² ⁴⁰³ ⁴⁰⁴ ⁴⁰⁵ ⁴⁰⁶ ⁴⁰⁷ ⁴⁰⁸ ⁴⁰⁹ ⁴¹⁰ ⁴¹¹ ⁴¹² ⁴¹³ ⁴¹⁴ ⁴¹⁵ ⁴¹⁶ ⁴¹⁷ ⁴¹⁸ ⁴¹⁹ ⁴²⁰ ⁴²¹ ⁴²² ⁴²³ ⁴²⁴ ⁴²⁵ ⁴²⁶ ⁴²⁷ ⁴²⁸ ⁴²⁹ ⁴³⁰ ⁴³¹ ⁴³² ⁴³³ ⁴³⁴ ⁴³⁵ ⁴³⁶ ⁴³⁷ ⁴³⁸ ⁴³⁹ ⁴⁴⁰ ⁴⁴¹ ⁴⁴² ⁴⁴³ ⁴⁴⁴ ⁴⁴⁵ ⁴⁴⁶ ⁴⁴⁷ ⁴⁴⁸ ⁴⁴⁹ ⁴⁵⁰ ⁴⁵¹ ⁴⁵² ⁴⁵³ ⁴⁵⁴ ⁴⁵⁵ ⁴⁵⁶ ⁴⁵⁷ ⁴⁵⁸ ⁴⁵⁹ ⁴⁶⁰ ⁴⁶¹ ⁴⁶² ⁴⁶³ ⁴⁶⁴ ⁴⁶⁵ ⁴⁶⁶ ⁴⁶⁷ ⁴⁶⁸ ⁴⁶⁹ ⁴⁷⁰ ⁴⁷¹ ⁴⁷² ⁴⁷³ ⁴⁷⁴ ⁴⁷⁵ ⁴⁷⁶ ⁴⁷⁷ ⁴⁷⁸ ⁴⁷⁹ ⁴⁸⁰ ⁴⁸¹ ⁴⁸² ⁴⁸³ ⁴⁸⁴ ⁴⁸⁵ ⁴⁸⁶ ⁴⁸⁷ ⁴⁸⁸ ⁴⁸⁹ ⁴⁹⁰ ⁴⁹¹ ⁴⁹² ⁴⁹³ ⁴⁹⁴ ⁴⁹⁵ ⁴⁹⁶ ⁴⁹⁷ ⁴⁹⁸ ⁴⁹⁹ ⁵⁰⁰ ⁵⁰¹ ⁵⁰² ⁵⁰³ ⁵⁰⁴ ⁵⁰⁵ ⁵⁰⁶ ⁵⁰⁷ ⁵⁰⁸ ⁵⁰⁹ ⁵¹⁰ ⁵¹¹ ⁵¹² ⁵¹³ ⁵¹⁴ ⁵¹⁵ ⁵¹⁶ ⁵¹⁷ ⁵¹⁸ ⁵¹⁹ ⁵²⁰ ⁵²¹ ⁵²² ⁵²³ ⁵²⁴ ⁵²⁵ ⁵²⁶ ⁵²⁷ ⁵²⁸ ⁵²⁹ ⁵³⁰ ⁵³¹ ⁵³² ⁵³³ ⁵³⁴ ⁵³⁵ ⁵³⁶ ⁵³⁷ ⁵³⁸ ⁵³⁹ ⁵⁴⁰ ⁵⁴¹ ⁵⁴² ⁵⁴³ ⁵⁴⁴ ⁵⁴⁵ ⁵⁴⁶ ⁵⁴⁷ ⁵⁴⁸ ⁵⁴⁹ ⁵⁵⁰ ⁵⁵¹ ⁵⁵² ⁵⁵³ ⁵⁵⁴ ⁵⁵⁵ ⁵⁵⁶ ⁵⁵⁷ ⁵⁵⁸ ⁵⁵⁹ ⁵⁶⁰ ⁵⁶¹ ⁵⁶² ⁵⁶³ ⁵⁶⁴ ⁵⁶⁵ ⁵⁶⁶ ⁵⁶⁷ ⁵⁶⁸ ⁵⁶⁹ ⁵⁷⁰ ⁵⁷¹ ⁵⁷² ⁵⁷³ ⁵⁷⁴ ⁵⁷⁵ ⁵⁷⁶ ⁵⁷⁷ ⁵⁷⁸ ⁵⁷⁹ ⁵⁸⁰ ⁵⁸¹ ⁵⁸² ⁵⁸³ ⁵⁸⁴ ⁵⁸⁵ ⁵⁸⁶ ⁵⁸⁷ ⁵⁸⁸ ⁵⁸⁹ ⁵⁹⁰ ⁵⁹¹ ⁵⁹² ⁵⁹³ ⁵⁹⁴ ⁵⁹⁵ ⁵⁹⁶ ⁵⁹⁷ ⁵⁹⁸ ⁵⁹⁹ ⁶⁰⁰ ⁶⁰¹ ⁶⁰² ⁶⁰³ ⁶⁰⁴ ⁶⁰⁵ ⁶⁰⁶ ⁶⁰⁷ ⁶⁰⁸ ⁶⁰⁹ ⁶¹⁰ ⁶¹¹ ⁶¹² ⁶¹³ ⁶¹⁴ ⁶¹⁵ ⁶¹⁶ ⁶¹⁷ ⁶¹⁸ ⁶¹⁹ ⁶²⁰ ⁶²¹ ⁶²² ⁶²³ ⁶²⁴ ⁶²⁵ ⁶²⁶ ⁶²⁷ ⁶²⁸ ⁶²⁹ ⁶³⁰ ⁶³¹ ⁶³² ⁶³³ ⁶³⁴ ⁶³⁵ ⁶³⁶ ⁶³⁷ ⁶³⁸ ⁶³⁹ ⁶⁴⁰ ⁶⁴¹ ⁶⁴² ⁶⁴³ ⁶⁴⁴ ⁶⁴⁵ ⁶⁴⁶ ⁶⁴⁷ ⁶⁴⁸ ⁶⁴⁹ ⁶⁵⁰ ⁶⁵¹ ⁶⁵² ⁶⁵³ ⁶⁵⁴ ⁶⁵⁵ ⁶⁵⁶ ⁶⁵⁷ ⁶⁵⁸ ⁶⁵⁹ ⁶⁶⁰ ⁶⁶¹ ⁶⁶² ⁶⁶³ ⁶⁶⁴ ⁶⁶⁵ ⁶⁶⁶ ⁶⁶⁷ ⁶⁶⁸ ⁶⁶⁹ ⁶⁷⁰ ⁶⁷¹ ⁶⁷² ⁶⁷³ ⁶⁷⁴ ⁶⁷⁵ ⁶⁷⁶ ⁶⁷⁷ ⁶⁷⁸ ⁶⁷⁹ ⁶⁸⁰ ⁶⁸¹ ⁶⁸² ⁶⁸³ ⁶⁸⁴ ⁶⁸⁵ ⁶⁸⁶ ⁶⁸⁷ ⁶⁸⁸ ⁶⁸⁹ ⁶⁹⁰ ⁶⁹¹ ⁶⁹² ⁶⁹³ ⁶⁹⁴ ⁶⁹⁵ ⁶⁹⁶ ⁶⁹⁷ ⁶⁹⁸ ⁶⁹⁹ ⁷⁰⁰ ⁷⁰¹ ⁷⁰² ⁷⁰³ ⁷⁰⁴ ⁷⁰⁵ ⁷⁰⁶ ⁷⁰⁷ ⁷⁰⁸ ⁷⁰⁹ ⁷¹⁰ ⁷¹¹ ⁷¹² ⁷¹³ ⁷¹⁴ ⁷¹⁵ ⁷¹⁶ ⁷¹⁷ ⁷¹⁸ ⁷¹⁹ ⁷²⁰ ⁷²¹ ⁷²² ⁷²³ ⁷²⁴ ⁷²⁵ ⁷²⁶ ⁷²⁷ ⁷²⁸ ⁷²⁹ ⁷³⁰ ⁷³¹ ⁷³² ⁷³³ ⁷³⁴ ⁷³⁵ ⁷³⁶ ⁷³⁷ ⁷³⁸ ⁷³⁹ ⁷⁴⁰ ⁷⁴¹ ⁷⁴² ⁷⁴³ ⁷⁴⁴ ⁷⁴⁵ ⁷⁴⁶ ⁷⁴⁷ ⁷⁴⁸ ⁷⁴⁹ ⁷⁵⁰ ⁷⁵¹ ⁷⁵² ⁷⁵³ ⁷⁵⁴ ⁷⁵⁵ ⁷⁵⁶ ⁷⁵⁷ ⁷⁵⁸ ⁷⁵⁹ ⁷⁶⁰ ⁷⁶¹ ⁷⁶² ⁷⁶³ ⁷⁶⁴ ⁷⁶⁵ ⁷⁶⁶ ⁷⁶⁷ ⁷⁶⁸ ⁷⁶⁹ ⁷⁷⁰ ⁷⁷¹ ⁷⁷² ⁷⁷³ ⁷⁷⁴ ⁷⁷⁵ ⁷⁷⁶ ⁷⁷⁷ ⁷⁷⁸ ⁷⁷⁹ ⁷⁸⁰ ⁷⁸¹ ⁷⁸² ⁷⁸³ ⁷⁸⁴ ⁷⁸⁵ ⁷⁸⁶ ⁷⁸⁷ ⁷⁸⁸ ⁷⁸⁹ ⁷⁹⁰ ⁷⁹¹ ⁷⁹² ⁷⁹³ ⁷⁹⁴ ⁷⁹⁵ ⁷⁹⁶ ⁷⁹⁷ ⁷⁹⁸ ⁷⁹⁹ ⁸⁰⁰ ⁸⁰¹ ⁸⁰² ⁸⁰³ ⁸⁰⁴ ⁸⁰⁵ ⁸⁰⁶ ⁸⁰⁷ ⁸⁰⁸ ⁸⁰⁹ ⁸¹⁰ ⁸¹¹ ⁸¹² ⁸¹³ ⁸¹⁴ ⁸¹⁵ ⁸¹⁶ ⁸¹⁷ ⁸¹⁸ ⁸¹⁹ ⁸²⁰ ⁸²¹ ⁸²² ⁸²³ ⁸²⁴ ⁸²⁵ ⁸²⁶ ⁸²⁷ ⁸²⁸ ⁸²⁹ ⁸³⁰ ⁸³¹ ⁸³² ⁸³³ ⁸³⁴ ⁸³⁵ ⁸³⁶ ⁸³⁷ ⁸³⁸ ⁸³⁹ ⁸⁴⁰ ⁸⁴¹ ⁸⁴² ⁸⁴³ ⁸⁴⁴ ⁸⁴⁵ ⁸⁴⁶ ⁸⁴⁷ ⁸⁴⁸ ⁸⁴⁹ ⁸⁵⁰ ⁸⁵¹ ⁸⁵² ⁸⁵³ ⁸⁵⁴ ⁸⁵⁵ ⁸⁵⁶ ⁸⁵⁷ ⁸⁵⁸ ⁸⁵⁹ ⁸⁶⁰ ⁸⁶¹ ⁸⁶² ⁸⁶³ ⁸⁶⁴ ⁸⁶⁵ ⁸⁶⁶ ⁸⁶⁷ ⁸⁶⁸ ⁸⁶⁹ ⁸⁷⁰ ⁸⁷¹ ⁸⁷² ⁸⁷³ ⁸⁷⁴ ⁸⁷⁵ ⁸⁷⁶ ⁸⁷⁷ ⁸⁷⁸ ⁸⁷⁹ ⁸⁸⁰ ⁸⁸¹ ⁸⁸² ⁸⁸³ ⁸⁸⁴ ⁸⁸⁵ ⁸⁸⁶ ⁸⁸⁷ ⁸⁸⁸ ⁸⁸⁹ ⁸⁹⁰ ⁸⁹¹ ⁸⁹² ⁸⁹³ ⁸⁹⁴ ⁸⁹⁵ ⁸⁹⁶ ⁸⁹⁷ ⁸⁹⁸ ⁸⁹⁹ ⁹⁰⁰ ⁹⁰¹ ⁹⁰² ⁹⁰³ ⁹⁰⁴ ⁹⁰⁵ ⁹⁰⁶ ⁹⁰⁷ ⁹⁰⁸ ⁹⁰⁹ ⁹¹⁰ ⁹¹¹ ⁹¹² ⁹¹³ ⁹¹⁴ ⁹¹⁵ ⁹¹⁶ ⁹¹⁷ ⁹¹⁸ ⁹¹⁹ ⁹²⁰ ⁹²¹ ⁹²² ⁹²³ ⁹²⁴ ⁹²⁵ ⁹²⁶ ⁹²⁷ ⁹²⁸ ⁹²⁹ ⁹³⁰ ⁹³¹ ⁹³² ⁹³³ ⁹³⁴ ⁹³⁵ ⁹³⁶ ⁹³⁷ ⁹³⁸ ⁹³⁹ ⁹⁴⁰ ⁹⁴¹ ⁹⁴² ⁹⁴³ ⁹⁴⁴ ⁹⁴⁵ ⁹⁴⁶ ⁹⁴⁷ ⁹⁴⁸ ⁹⁴⁹ ⁹⁵⁰ ⁹⁵¹ ⁹⁵² ⁹⁵³ ⁹⁵⁴ ⁹⁵⁵ ⁹⁵⁶ ⁹⁵⁷ ⁹⁵⁸ ⁹⁵⁹ ⁹⁶⁰ ⁹⁶¹ ⁹⁶² ⁹⁶³ ⁹⁶⁴ ⁹⁶⁵ ⁹⁶⁶ ⁹⁶⁷ ⁹⁶⁸ ⁹⁶⁹ ⁹⁷⁰ ⁹⁷¹ ⁹⁷² ⁹⁷³ ⁹⁷⁴ ⁹⁷⁵ ⁹⁷⁶ ⁹⁷⁷ ⁹⁷⁸ ⁹⁷⁹ ⁹⁸⁰ ⁹⁸¹ ⁹⁸² ⁹⁸³ ⁹⁸⁴ ⁹⁸⁵ ⁹⁸⁶ ⁹⁸⁷ ⁹⁸⁸ ⁹⁸⁹ ⁹⁹⁰ ⁹⁹¹ ⁹⁹² ⁹⁹³ ⁹⁹⁴ ⁹⁹⁵ ⁹⁹⁶ ⁹⁹⁷ ⁹⁹⁸ ⁹⁹⁹ ⁹⁹⁹⁹

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 12:00 NOON	
GLADYS TAYLOR		KRAUSS	9	15 68		
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years lost/birthday)	7. COUNTY OF DEATH	2b. HOUR 12:00 NOON	
F	W	1-26-1900	68 yrs.	CECIL		
7b. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
MD	U.S.A.		RETT PERRY POINT	GROUT		
14. FATHER'S NAME	First	Middle	15. MOTHER'S MAIDEN NAME	First	Middle	Last
HARRY	N.	TAYLOR	MARY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address			
NO		APRIL D. CALDWELL	ELADON M.D.			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
24 hours						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)						
Cardio arteriosclerosis						
19c. DATE OF OPERATION		19d. CONDITION FOR WHICH OPERATION WAS PERFORMED		20e. AUTOPSY?	20f. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.	City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from 9/14, 1968, to 9/15, 1968, that (I) (we) last saw the deceased alive on 9/15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE Edgar E. Folk III, M.D.						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22c. DATE SIGNED 9/15/68		
Edgar E. Folk III		155 Ave. "A", Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23c. NAME OF CEMETERY OR CEMETORY		23d. LOCATION (City or Town) COLORA	(County) CECIL	(State) MD.
BURIAL		WEST NOTTINGHAM				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR SEP 18 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	
Robert F. Folck		ELKTON MD.				

12839

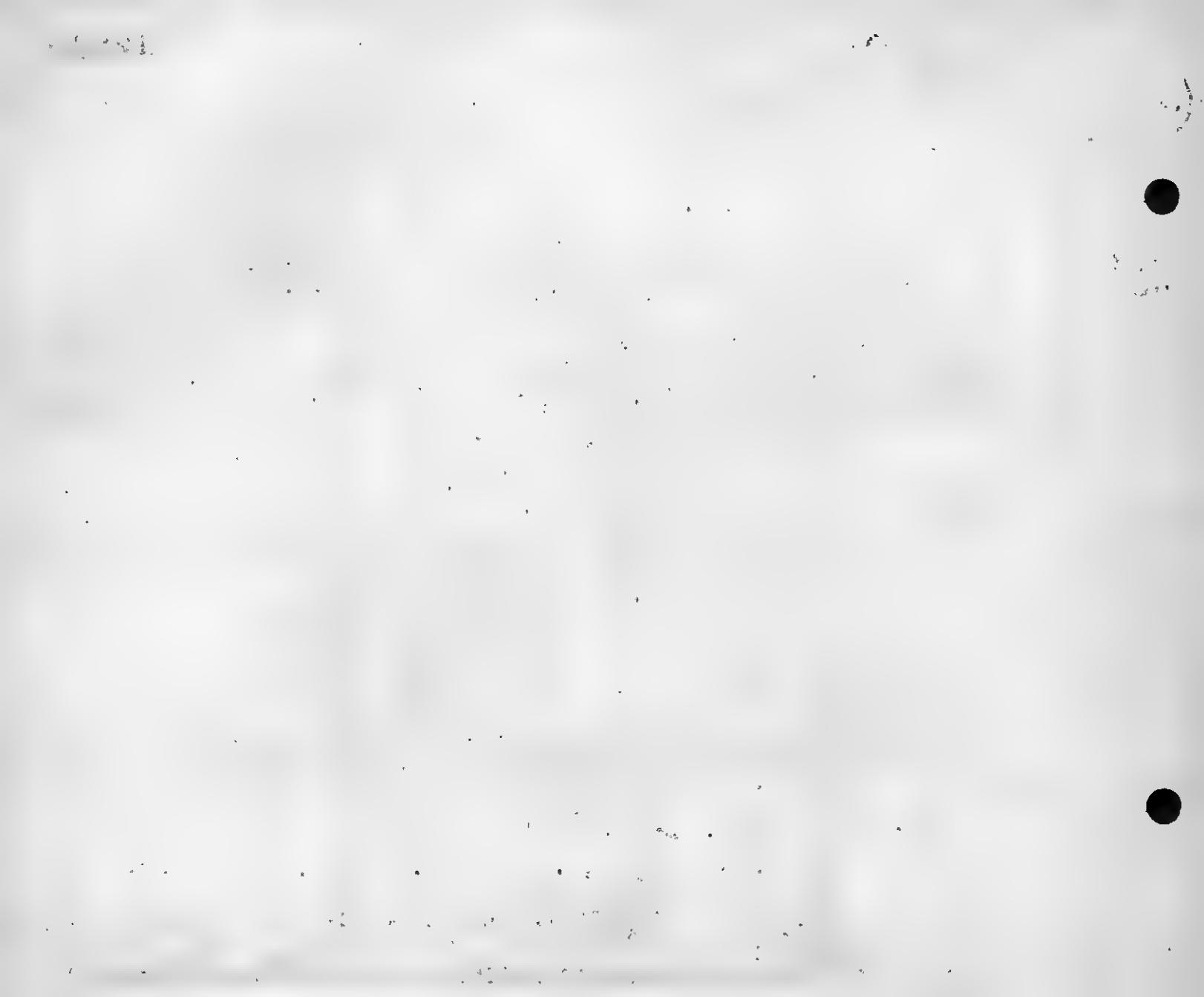
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12849

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (2 pages) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First Fred	Middle rick	Last Martine	2a DATE OF DEATH Month 9	Day 11	Year 1968	2b. HOUR 10:55	
3 SEX Male		4 RACE White	5. DATE OF BIRTH March 9, 1899		6. AGE (in years last birthday) 69		IF UNDER 1 YEAR MONTHS YRS.		
7a BIRTHPLACE (State or foreign country) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil		10b. KIND OF BUSINESS OR INDUSTRY Plastics		
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital (by street address) Union Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Oven tender		12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Cecil	13c. CITY OR TOWN Norfolk East	13d. INSIDE CITY LHM 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER R.F.D. # 1, Box 127				
14. FATHER'S NAME First Joseph		Middle Martine	15. MOTHER'S MAIDEN NAME First Eva		Middle Stockton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 166-05-7532		17. INFORMANT Mrs. Wilhelmina Martine (Wife) Same		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardiac Failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-Weeks			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Myocarditis				5- Years			
		DUE TO, OR AS A CONSEQUENCE OF (c) Nephritis				4- Years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that (I) <input type="checkbox"/> attended the deceased from 7/28/1968, to 9/11/1968, that (I) <input type="checkbox"/> last saw the deceased alive on 9/11/1968, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE James L. Johnson M.D.		M.D. DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 9/13/68		
22d. PHYSICIAN'S NAME (Type) James L. Johnson M.D.		22e. ADDRESS 241 E. High St., Elkton, Md. Cecil							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-14-68	23c. NAME OF CEMETERY OR CREMATORIAL Friends Burying Grounds		23d. LOCATION (City or Town) Calvert		(County) Cecil	(State) Md.	
24. FUNERAL DIRECTOR Grant Funeral Home		ADDRESS Box 22 North East, Md.		25a. RECD BY REGISTRAR DATE SEP 16 1968		25b. REGISTRAR'S SIGNATURE Charles J. Crouch			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

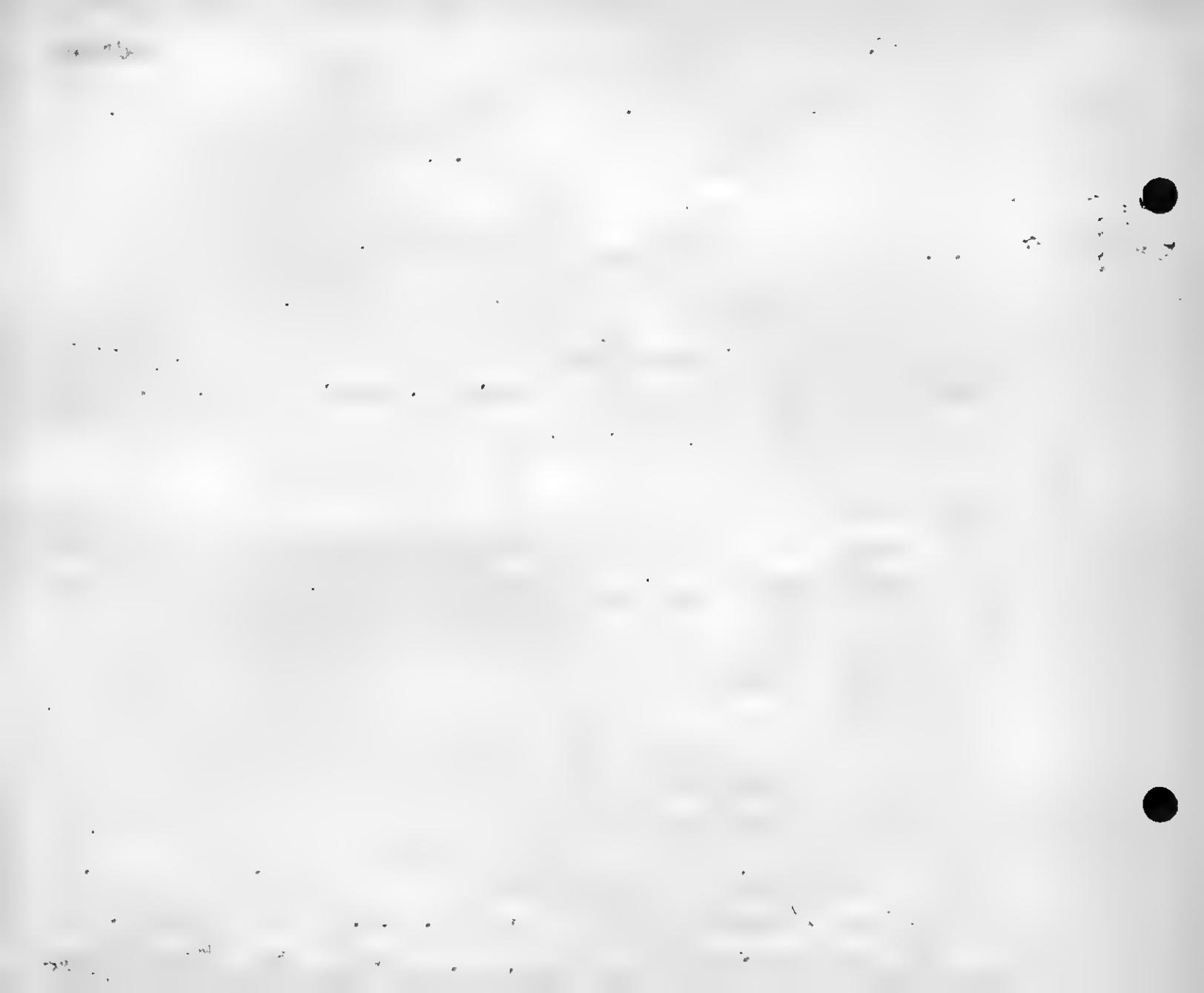
CERTIFICATE OF DEATH

12840

12850

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the funeral.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cinnarion, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Florence	Middle R.	Last Mason	2a. DATE OF DEATH Month 9	2b. HOUR Year 1968
3. SEX Female	4. RACE White	5. DATE OF BIRTH Jan. 4, 1891		6. AGE (in years lost birthday) 77	7. IF UNDER 24 HRS MONTHS DAYS HOURS M
7a. BIRTHPLACE (State or foreign country) Delaware	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Cecil		
10. CITY OR TOWN OF DEATH R.D. Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Residence		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY --	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER R.D.	
14. FATHER'S NAME First Robert	Middle R.	Last Reed	15. MOTHER'S MAIDEN NAME First Ina	Middle Cooper	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO (If yes give war or dates of service)	17. INFORMANT Robert R. Mason, Elkton, Md.	Address R.D.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>for FISCILLATION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>marked CARDIOMEGALY</u> , <u>Possible old Rheumatic heart disease</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH</u> , 19 <u>68</u> , to <u>graves</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/2/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Robert L. Gray</u>	MD DEGREE	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <u>9/10/68</u>
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS 123 W. High St., Elkton, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 9/13/68	23c. NAME OF CEMETERY OR CREMATORIAL Cherry Hill Meth. Cem. Cherry Hill, Md.	23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR Hicks	ADDRESS Hicks Home for Funerals, Elkton, Md.	25a. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>Robert L. Gray</u>		
VR A15 30M REV. 1	DATE SEP 16 1988				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12841

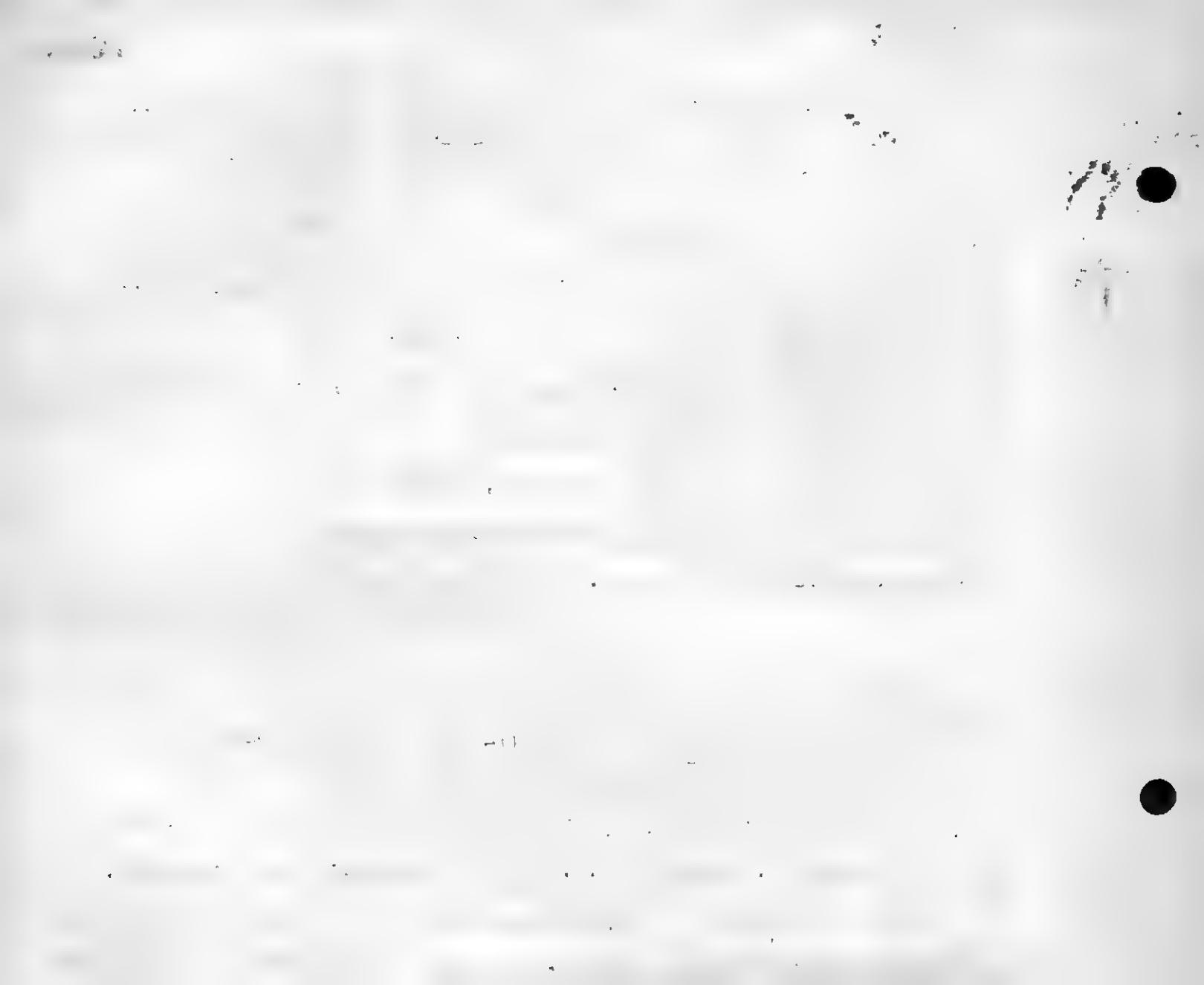
CERTIFICATE OF DEATH

12851

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 2 and 3, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)	First	Middle	Lost	2a. DATE OF DEATH Month	9	Day	17	Year	68	2b. HOUR
CLYDE NORMAN										
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH 2-10-95			6. AGE (In years last birthday) 73		IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS. DAYS
7a. BIRTHPLACE (State or foreign country) Rover City, NC		7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Cecil					
10. CITY OR TOWN OF DEATH Perry Point, Md		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or street address) VA Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Wilmington, DEL.		13b. COUNTY	13c. CITY OR TOWN Wilmington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 213 Poplar Street					
14. FATHER'S NAME Abraham Norman	First	Middle	Lost	15. MOTHER'S MAIDEN NAME Unknown	First	Middle	Lost			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. WW I	17. INFORMANT VA Records, VAH, Perry Point, Maryland			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY.										
IMMEDIATE CAUSE (a) Coronary thrombosis										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) Diabetes Mellitus, severe										
DUE TO, OR AS A CONSEQUENCE OF										
(c) Arteriosclerotic Heart Disease										
APPROXIMATE INTERVAL BETWEEN ONSET AND										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Chronic brain syndrome assoc. w/arteriosclerosis										
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State			
22a. I certify that (b) (this hospital) attended the deceased from 11-17, 19 44, to 9-17- 19 68, that (a) (we) lost saw the deceased alive on 9-17 19 68, and that in (b) (our) opinion death occurred on the date and hour and from the causes stated above. (a) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Thomas R. Huxtable, M.D.</i>		DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 9-19-68				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS VA Hospital, Perry Point, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9-18-68	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Baltimore National			23d. LOCATION (City or Town) Near Darlington			(County)	(State) Baltimore Maryland
24. FUNERAL DIRECTOR <i>Pennington & Son, Navre de Grace, Md.</i>					25a. REC'D BY REGISTRAR DATE SEP 24 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12842

12852

DECEASED NAME (Type or Print)	First	Middle	Last	2a. DATE KNOWN OF ESTIMATE	Month	Day	Year	2b. HOUR
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (in years last birthday) OYRS.	7. IF UNDER 1 YEAR	8. F. UNDER 24 HRS.			
MONTH	WHITE	DEC 28 1898	MONTHS	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH	2c. DATE PRONOUNCED DEAD	Month	Day	Year	2d. HOUR
MARYLAND	U.S.A.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	ELKTON	SEPT 24	1968	8 A.M.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY					
ELKTON	609 NORTH ST	CONSTRUCTION	CHERRY LANE					
13a. US/JAL RESIDENCE (Where deceased lived, if institution admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER				
MARYLAND	CECIL	ELKTON	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	609 North St.				
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
John	L	PETERSON		MAMIE			CACIA	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO (If yes, give war or dates of service)	17. INFORMANT	ADDRESS					
NO	46-07-2648	HENRILITA GREGORY	RD #5 ELKTON MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				ONE YEAR TWO YEARS				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE	HENRY V. DAVIS							
EXAMINER'S NAME (Type)	HENRY V. DAVIS M.D.							
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City or Town) (County) (State)					
BURIAL	9/18/68	Cherry Hill Meth. Cem	Cherry Hill, Md.					
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE					
Ralph E. Sticks	Hicks Home for Funerals, Elkton, Md.	SEP 16 1968	Charles Judge					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12842 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12853

1 DECEASED NAME (Type or Print)	First PAUL	Middle E.	Last PLITT	2a. DATE KNOWN OF DEATH ESTIMATED	Month Sept.	Day 19	Year 1968	2b. HOUR 11:10	
3 SEX Male	4. RACE White	5. DATE OF BIRTH 9/17/68	6 AGE (In years at birthday) 42	7. UNDER 1 YEAR MONTHS YRS.	8. UNDER 24 HRS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Sept.			2d. HOUR 11:10
7a. BIRTHPLACE (State or foreign country) Delaware	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Cecil					
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Blue Ball Rd. near WaterTower			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Lather			12b. KIND OF BUSINESS OR INDUSTRY Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE Maryland	13b. COUNTY Cecil	13c. CITY OR TOWN Childs	13d. INSIDE CTY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER					
14. FATHER'S NAME Charles	Middle E.	Last Plitt	15. MOTHER'S MAIDEN NAME Bertha	Middle	Last Hersch				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16b. SOCIAL SECURITY NO. WW 2	17. INFORMANT Mrs. Bertha H. Plitt	ADDRESS Newark, Del. RD#2						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 5/11.8 Conditions, if any, which gave rise to immediate cause (a). stating the <u>underlying cause</u> lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5/11									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town	County	State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE RONALD N. KORNBLUM		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		22b. DATE SIGNED September 20, 1968 ADDRESS (Street, city, town, or county) Meyersdale, Penna.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/23/68		23c. NAME OF CEMETERY OR CREMATORIAL Union Cemetery		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR R.T. Jones		ADDRESS Rewalk, Delaware		25a. REC'D BY REGISTRAR DATE SEP 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

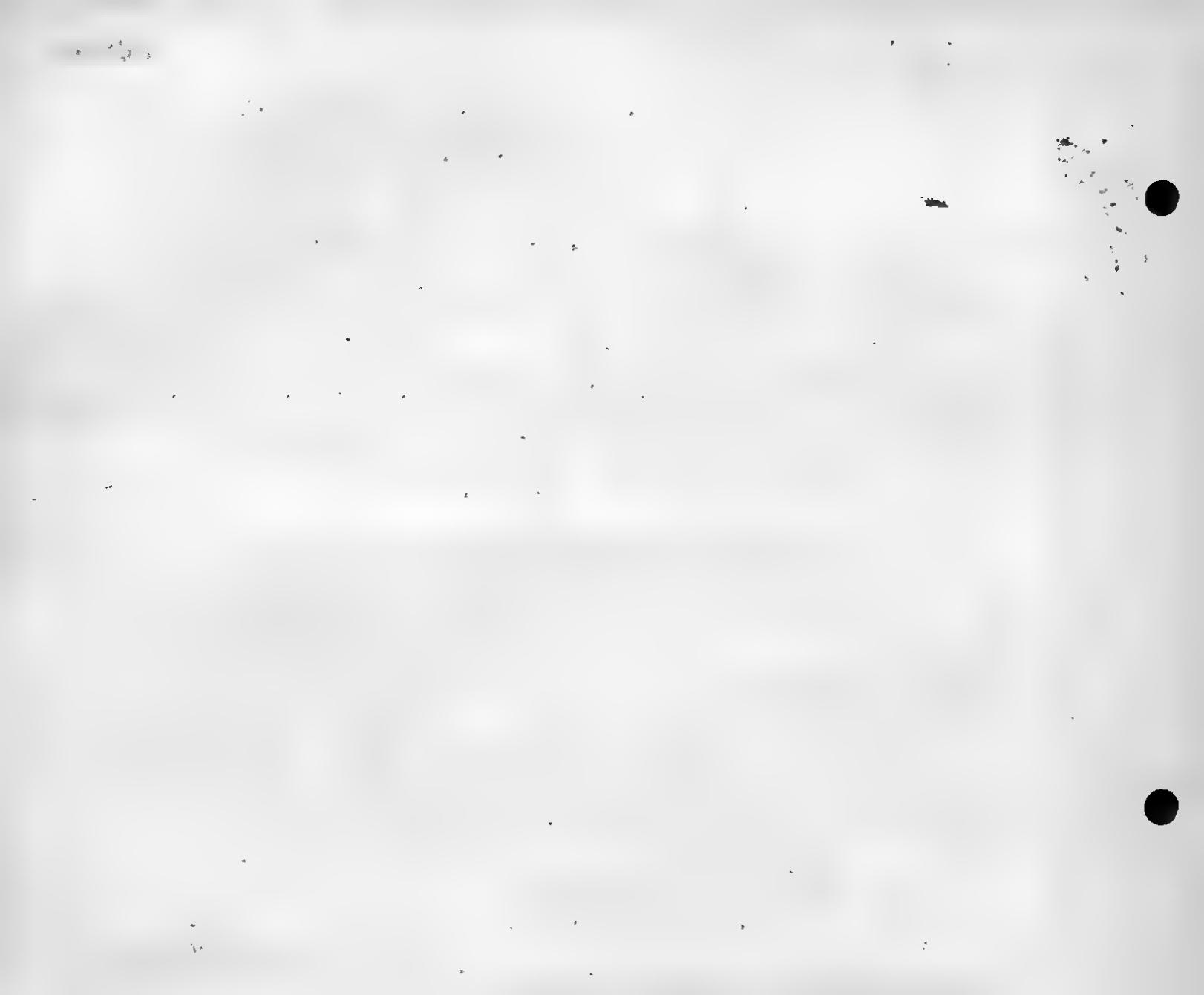
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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Orlena	Middle R.	Lost Potts	2a DATE OF DEATH Month September Year 1968 2b. HOURS 5:45 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH Sept. 8, 1890		6. AGE (In years lost birthday) 78 yrs.
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Cecil	
10 CITY OR TOWN OF DEATH Elkton	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b KIND OF BUSINESS OR INDUSTRY --
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland	13b. COUNTY Cecil	13c CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 306 Park Circle
14. FATHER'S NAME First Floyd	Middle Rogers	15. MOTHER'S MAIDEN NAME First Rachel	Middle Cosner	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 217-48-7065	17. INFORMANT S. Alfred Potts, Elkton, Md.	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4-1 Due to, or as a consequence of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Due to, or as a consequence of (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331				
19a. DATE OF OPERATION 331		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or RFD No	City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from <u>August 18 1968</u> , to <u>Sept 22 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept 22 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>S. Ralph Andrews, Jr. M.D.</i>		DEGREE MED DEGREE ATTENDING PHYS MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 9-23-68	
22d. PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, Jr.		22e. ADDRESS 233 E. Main St., Elkton, Md.		
23a. BURIA, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/25/68	23c. NAME OF CEMETERY OR CREMATORIUM Elkton Cemetery	23d. LOCATION (City or Town) Elkton, Md.	(County) (State)
24. FUNERAL DIRECTOR <i>Ralph E. Hicks</i>		ADDRESS Hicks Home for Funerals, Elkton, Md.	25a. REC'D. BY REGISTRAR DATE SEP 25 1968	25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

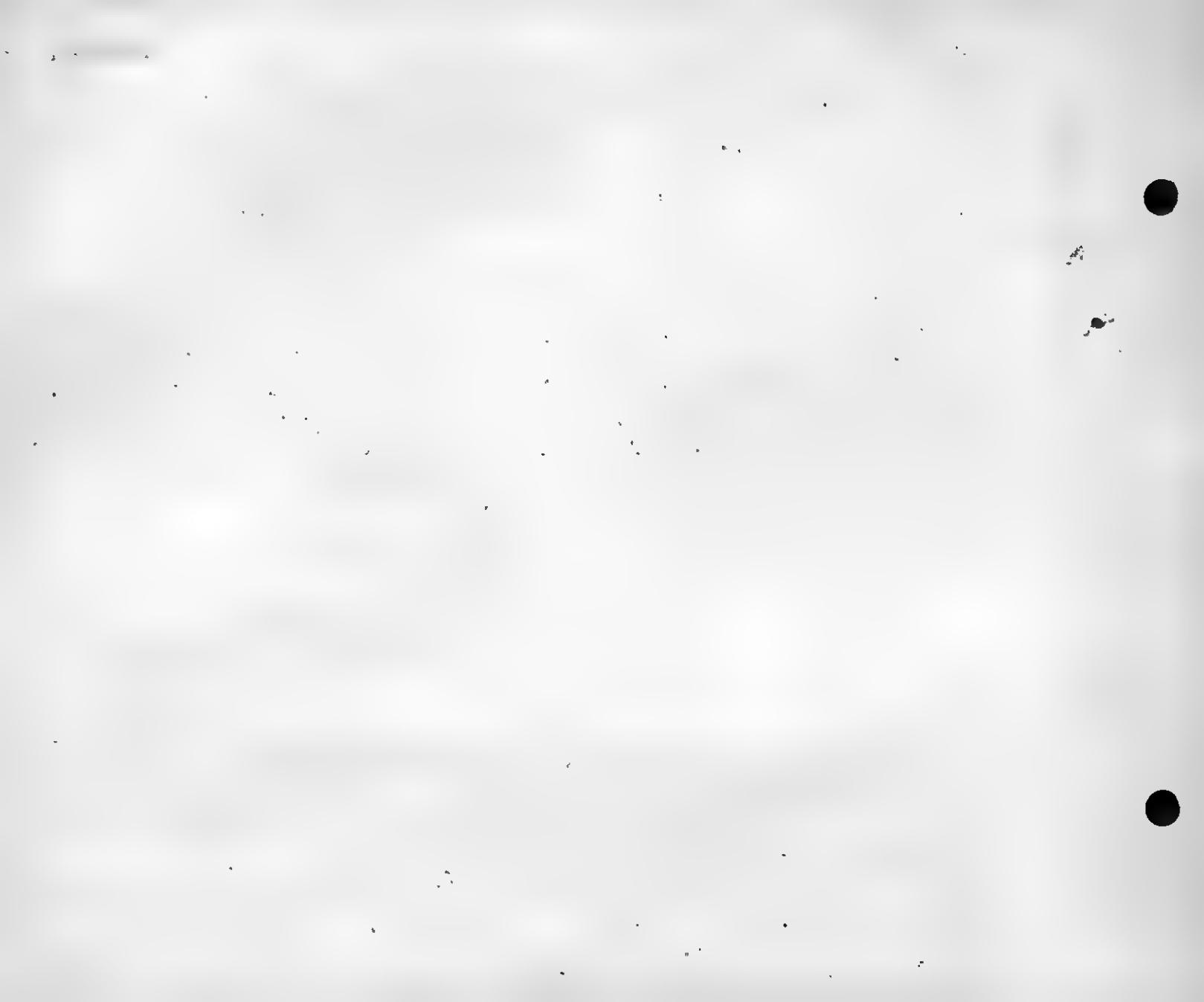
12845

12855

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

2 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (page 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1 DECEASED-NAME (Type or print)	First <i>FRANK</i>	Middle <i>J.</i>	Last <i>POWELL</i>	2a. DATE OF DEATH Month <i>9</i>	Year <i>68</i>	2b. HOUR <i>9:45 P.M.</i>		
3. SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>11-9-11</i>		6. AGE (in years last birthday) <i>58</i>		IF UNDER MONTHS <i>58</i>	YEAR <i>YRS.</i>	IF UNDER 24 HRS. HOURS MIN. <i>00</i>
7a BIRTHPLACE (State or foreign country) <i>HOLLAND</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>CECIL</i>		Md.		
10. CITY OR TOWN OF DEATH <i>ELKTON</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>UNION</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>GARD.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>LAND.</i>			
13a. USUAL RESIDENCE (Where deceased admission) STATE <i>MD.</i>	lived, if institution Residence before 13b. COUNTY <i>CECIL</i>	13c. CITY OR TOWN <i>ELKTON</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>RP #2</i>				
14. FATHER'S NAME First <i>ALBERT</i>	Middle <i>POWELS</i>	15. MOTHER'S MAIDEN NAME First <i>THEODORA</i>	Middle <i>HERMSEN</i>	Address <i>ELKTON, MD.</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>	16b. SOCIAL SECURITY NO <i>213-36-7928</i>	17 INFORMANT <i>EMMA POWELL</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 minutes</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ventricular Fibrillation</i>								
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause <i>4104</i>								
(b) <i>Acute Myocardial Infarction</i> 14 days								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION <i>4/4/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (i) (this hospital) attended the deceased from <i>9/4/68</i> to <i>9/4/68</i> , that (ii) (we) last saw the deceased alive on <i>9/4/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (ii) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Joseph S. Lanz</i>		DEGREE ATTENDING PHYS	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS	22c. DATE SIGNED <i>9-4-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>JOSEPH S. LANZ</i>		22e. ADDRESS <i>ELKTON, MD.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>9-7-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>IMMACULATE CONCEPTION</i>		23d. LOCATION (City or Town) <i>CHERRY HILL</i>	(County) <i>CECIL</i>	(State) <i>MD.</i>	
24. FUNERAL DIRECTOR <i>Pippin Funeral Home</i>		ADDRESS <i>Elkton</i>	25a. REC'D BY REGISTRAR <i>Robert L. Lanz</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
304A REV 1-68		DATE SEP 9 1968						



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 5 may be retained for your files.

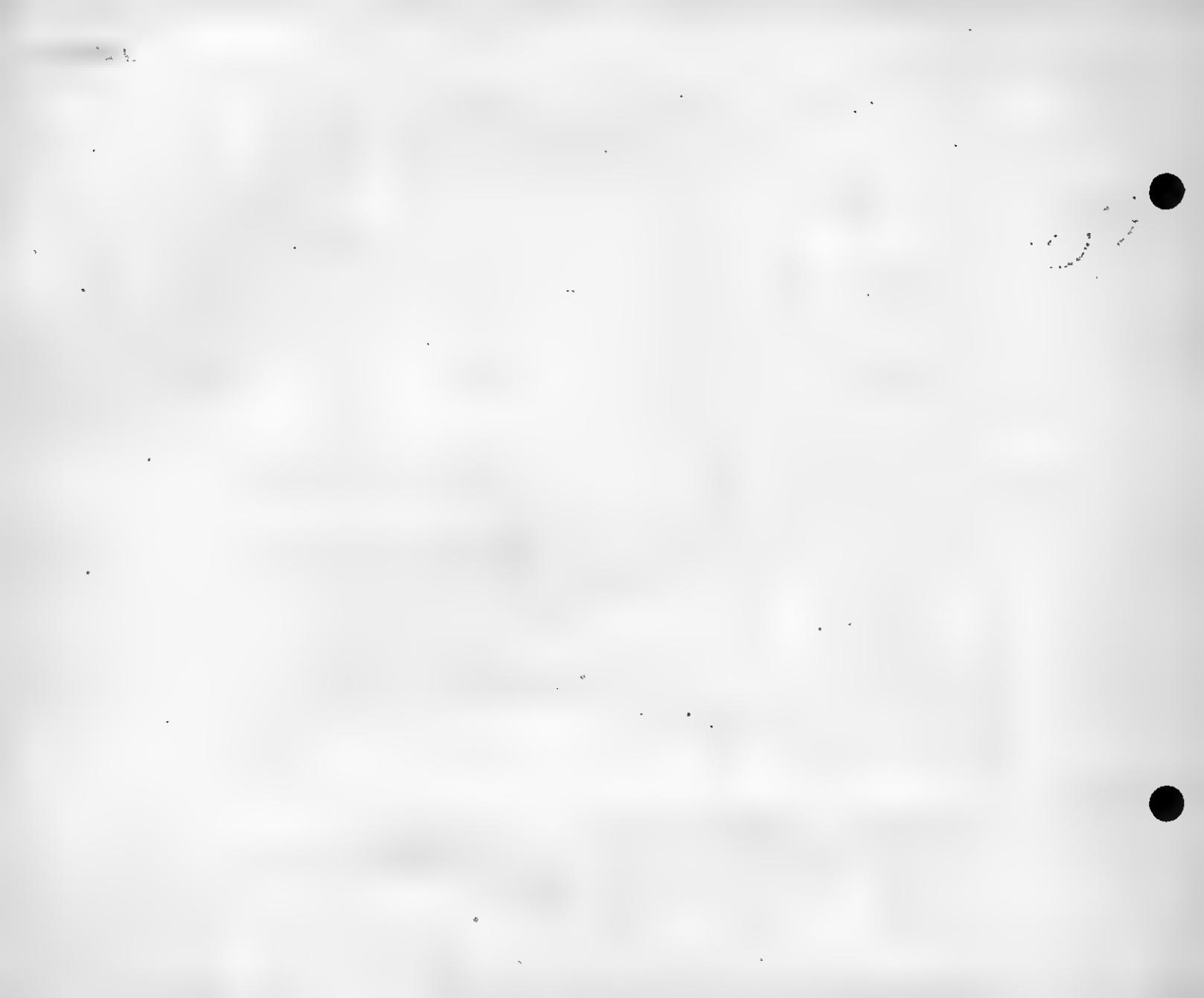
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12856

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF EST. DEATH MATED	Month	Day	Year	2b. HOUR			
<u>WILLIE JAMES CLAYTON SANDERS</u>					<u>SANDERS</u>	<input checked="" type="checkbox"/>	9	7	68	M			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	F UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	7c DATE PRONOUNCED DEAD Month	Day	Year	2d HOUR				
MALE	WHITE	6-3-26	42 yrs			9	7	68	1:58 PM				
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8.	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 COUNTY OF DEATH <u>CECIL</u>									
10 CITY OR TOWN OF DEATH <u>ELKTON</u>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>UNION HOSPITAL</u>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>ELKTON JANITOR</u>			12b KIND OF BUSINESS OR INDUSTRY <u>DRIVE-IN RESTAURANT</u>						
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <u>DELAWARE</u> COUNTY <u>NEWCASTLE</u>	13c CITY OR TOWN <u>NEWARK</u>	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/>	13e STREET AND NUMBER <u>OLD POST ROAD RD 2</u>										
14 FATHER'S NAME <u>WILLIE</u>	First	Middle	Last	15 MOTHER'S MAIDEN NAME <u>SANDERS</u>	First	Middle	16a WAS DECEASED EVER (Yes, no, or unknown) <u>NO</u>	16b SOCIAL SECURITY NO (If yes give war or dates of service) <u>407-22-3734</u>	17. INFORMATION <u>HELLERADKINS 915 HARRIS DRIVERS LICENSE</u>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HEMORRHAGE PT. FENOROL VESSELS</u> DUE TO, OR AS A CONSEQUENCE OF <u>COMPOUND FRACTURE FEMUR AT PT. GRAN</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>01.4</u> (c)	19. DATE OF OPERATION <u>19a</u>	19b CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>19b</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>TWO COMPOUND FRACTURES PT. LEG-FRACTURED MANDIBLE-FRACTURED LEFT WRIST</u>										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 21a-21c) <u>19c</u>			
21a. DATE OF OPERATION		21b TIME OF INJURY Month, Day, Year HOUR A.M. / P.M. <u>1:30 9/7 68</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 21a-21c) <u>19c</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office, business, <u>281 EAST OF ELKTON</u> 0.2 MILE EAST OF ELKTON CECIL MD		21f LOCATION Street or R.F.D. No. <u>STATE ST 181</u> County <u>CECIL</u> State <u>MD</u>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22b DATE SIGNED <u>9/7/68</u>			
ACTUAL SIGNATURE <u>Henry V. Davis</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) <u>HENRY V. DAVIS MD</u>		ADDRESS <u>101 S. 4TH ST. CECIL CITY MD</u>		23d LOCATION (City or Town) (County) (State) <u>Wilmington, Delaware</u>									
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE <u>9/10/68</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Lombardy Cem.</u>		23d LOCATION (City or Town) (County) (State) <u>Wilmington, Delaware</u>							
24 FUNERAL DIRECTOR <u>R. T. Jones Newark, Delaware</u>		ADDRESS		25a REC'D BY REGISTRAR <u>SEP 9 1968</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>							



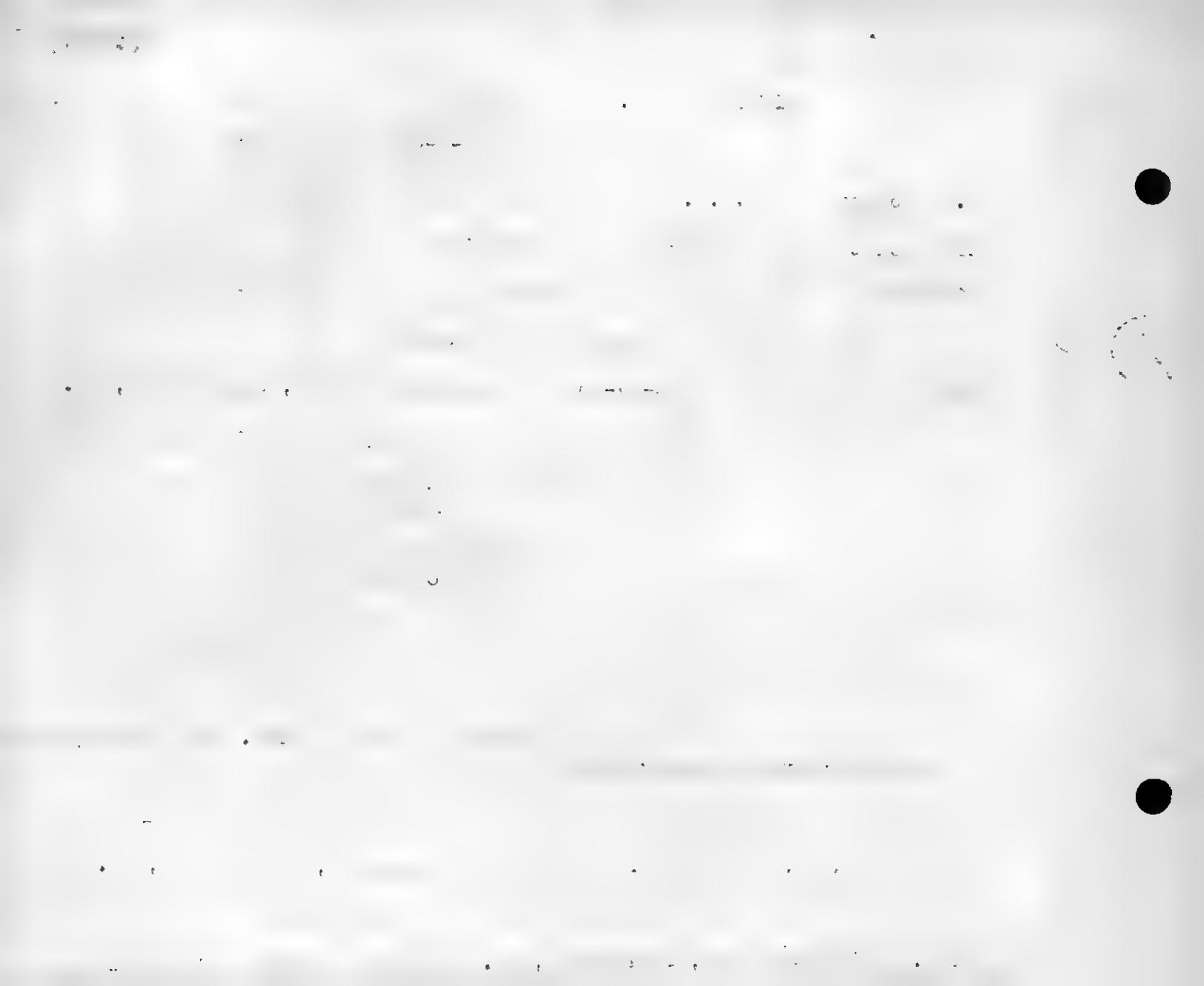
CERTIFICATE OF DEATH

12857

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First CLIFTON	Middle R.	Last SPIRES	2a. DATE OF DEATH Month 9 Day 10 Year 68	2b. HOUR 9:05a		
3. SEX Male	4 RACE White	5. DATE OF BIRTH 11-9-09		6. AGE (In years last birthday) 58 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) S. Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Cecil				
10. CITY OR TOWN OF DEATH Perry Point	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Georgia	13b. COUNTY	13c. CITY OR TOWN Augusta	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 1836 Greene Street			
14. FATHER'S NAME John	First Spires	Middle Unknown	15. MOTHER'S MAIDEN NAME First Unknown	Middle 	Last 		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO (If yes give war or dates of service) WW II	16c. INFORMANT VA Hospital Records, Perry Point, Md.	Address				
17. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) Massive hydrothorax, right side							
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive/pleural effusion, right side (650 cc)							
DUE TO, OR AS A CONSEQUENCE OF Pulmonary tuberculosis, acute							
(b) Massive/confluent bronchopneumonia with fulminating							
DUETO, OR AS A CONSEQUENCE OF multiple Abscesses							
(c) (smear & culture positive for mycobacterium tuberculosis)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
Other Emphysematous changes of lungs							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. 1 Month Day Year P.M. 39	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work	21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 24 , 19 48 , to Sept. 10 , 19 68 , 1968 saw the deceased alive 1948-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. L. Mooney, M.D.	22c. DATE SIGNED 9-11-68						
22d. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.	22e. ADDRESS VA Hospital, Perry Point, Md.						
23a. BURIAL, CREMATION/ REMOVAL (Specify) 1968	23b. DATE 14/68	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Amherst Sq. Westview Cem. Augusta	23d. LOCATION (City or Town) (County) Georgia				
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.	25a. REC'D BY REGISTRAR DATE SEP 25 1968	25b. REGISTRAR'S SIGNATURE Charles Judge					



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PWS-Pg 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

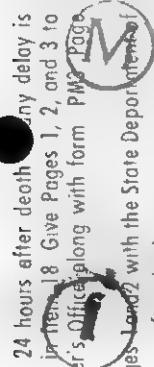
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12858

1 DECEASED NAME JULIAN RICHARD SPRY, SR.			2a DATE KNOWN <input type="checkbox"/> OF EST. <input type="checkbox"/> DEATH MATED Sept. 16, 1968	Month Day Year Sept. 16, 68	2b HOUR 12:35 M				
3 SEX Male	4 RACE White	5 DATE OF BIRTH June 17, 1892	6 AGE (in years last birthday) 76 yrs	7f UNDER 1 YEAR MONTHS 0	7f UNDER 24 HRS DAYS 0	7f UNDER 24 HRS HOURS 0	7f UNDER 24 HRS MIN 0	2c. DATE PRONOUNCED DEAD Month Day Year Sept. Day 16, 1968	2d HOUR 12:35 M
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Cecil			
10. CITY OR TOWN OF DEATH Elkton		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer		12b KIND OF BUSINESS OR INDUSTRY Farming			
13a US/JAI RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Cecil		13c CITY OR TOWN Elkton		13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER Rd. 4	
14 FATHER'S NAME William		First Middle Last L. Spry		15 MOTHER'S MAIDEN NAME Charlotte					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO (If yes give war or dates of service)		17 INFORMANT		ADDRESS			
						Mrs. Gertrude E. Spry, Elkton, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY Shotgun wound of head									
IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20 AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
21a MEDICAL CERTIFICATION		21b TIME OF INJURY Month, Day, Year 12:00 P.M. Sept. 16, 68		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) Shot self in head					
21d EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f LOCATION Street or R.F.D. No Rd. 4		City or Town Elkton		County Cecil	State M.D.
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>		Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>		and in my opinion					
death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Ronald N. Kornblum		EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED September 17, 1968	
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b DATE 9/19/68		23c NAME OF CEMETERY OR CREMATORIAL Gilpin Manor Memorial Park, Elkton, Md.		23d LOCATION (City or Town) Park, Elkton, Md.		(County) 	(State)
24 FUNERAL DIRECTOR Sophie E. Hicks		ADDRESS Hicks Home for Funerals, Elkton, Md.		25a REC'D BY REGISTRAR SEP 25 1968		25b REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.



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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12849 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12859

1 DECEASED NAME (Type or Print)	First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b HOUR			
Thomas Stanley				9-24 1968 6 P.M.							
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE YEARS	7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED WIDOWED	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. JSJAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
M	W	6-14-55	73	N.J.	U.S.A.	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			D.O.A. Union Hosp.	Asphalt Paver	Painting
10 CITY OR TOWN OF DEATH	11 CITY OR TOWN	13a USUAL RESIDENCE (Where deceased lived, if institutional, Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER					
EIKTON	D.O.A. Union Hosp.	Md.	Cecil	EIKTON	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	R.D. 1, Box 5 (Trailer Park)					
14. FATHER'S NAME	First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle	Last				
Thomas Stanley				Tessie Hicks							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Yes	W.W. 2	Emma Stanley	R.D. 1, Box 5 EIKTON Md.	Unk.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town	County	State			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John M. Byers</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 9-24-68					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<i>John M. Byers, M.D.</i>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 9-28-68		23c NAME OF CEMETERY OR CREMATORIAL Silver Brook		23d LOCATION (City or Town) Wilmington, New Castle Del.		(County) (State)			
24 FUNERAL DIRECTOR Grant Funeral Home		ADDRESS 1000 N. Market Street, North East, Md.		25a REC'D BY REGISTRAR Charles Judge		25b REGISTRAR'S SIGNATURE					
DATE SEP 27 1968											

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12860

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be rejoined by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Helen	Middle Lort	Last Teeter	2a. DATE OF DEATH Month 9	Day 26	Year 68	2b. HOUR 7:10 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH Dec. 21, 1879			6. AGE (In years last birthday) 88	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Penns.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Cecil				
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 141 Main St.			
14. FATHER'S NAME Joseph	First Lort	Middle	Last	15. MOTHER'S MAIDEN NAME Martha	Middle	Last	McCleary
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO.	17. INFORMANT J. Ewing Lort, Elkton, Md.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200 (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1. Volvulus, Bismaid colon. 2. Compression L-5, osteoporosis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (This hospital) attended the deceased from <u>8-23-1968</u> , to <u>9-26-1968</u> , that (I) (we) last saw the deceased alive on <u>9-26-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Tillman D. Johnson M.D.</u>		ATTENDING DEGREE PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>9-26-68</u>		
22d. PHYSICIAN'S NAME (Type) Tillman D. Johnson M.D.		22e. ADDRESS 123 Singlety Ave. Elkton, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/1/68	23c. NAME OF CEMETERY OR CREMATORIAL Sharps Cemetery		23d. LOCATION (City or Town) Fair Hill	(County) Cecil	(State) Md.
24. FUNERAL DIRECTOR Hicks		ADDRESS Home for Funerals, Elkton, Md.	25a. REC'D. BY REGISTRAR DATE OCT 7 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12862

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Pearl R.	Middle	Last Weller	2a. DATE OF DEATH Month Sept. 5 Year 1968	2b. HOUR 5:10 P.M.		
3. SEX Female	4. RACE White	S. DATE OF BIRTH June 6, 1888	6. AGE (in years last birthday) 80 yrs.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Penns.	7b. CITIZEN OF WHAT COUNTRY? USA	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Cecil	10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland	13b. COUNTY Cecil	13c. CITY OR TOWN North East	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 122 S. Main St.			
14. FATHER'S NAME First James F. Reburn	Middle	Last	15. MOTHER'S MAIDEN NAME First Amanda Minnick	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO.	17. INFORMANT James H. Weller	Address North East, Md.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) <u>Arteriosclerotic cardiovascular disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 4221							
19a. DATE OF OPERATION 2	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (the hospital) attended the deceased from <u>7-6-63</u> to <u>9-5-68</u> , that (I) (we) last saw the deceased alive on <u>9-2-68</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. Barnhart Jr.	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED 9-9-68			
22d. PHYSICIAN'S NAME (Type) Jay S. Barnhart Jr.	22e. ADDRESS 4 Mauldin Ave. North East, Md.						
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-9-68	23c. NAME OF CEMETERY OR CREMATORIUM Oxford Cemetery	23d. LOCATION (City or Town) Oxford	(County) Chester	(State) Pa.		
24. FUNERAL DIRECTOR Grant Funeral Home	ADDRESS Box 22 North East, Md.	25a. REC'D BY REGISTRAR SEP 10 1968	25b. REGISTRAR'S SIGNATURE Charles J. George				

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